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The table printed below lists regulation sections, by Virginia Administrative Code (VAC) title, that have been amended, added or repealed in the *Virginia Register* since the regulations were originally published or last supplemented in VAC (the Fall 2003 VAC Supplement includes final regulations published through *Virginia Register* Volume 19, Issue 24, dated August 11, 2003). Emergency regulations, if any, are listed, followed by the designation "emer," and errata pertaining to final regulations are listed. Proposed regulations are not listed here. The table lists the sections in numerical order and shows action taken, the volume, issue and page number where the section appeared, and the effective date of the section.

SECTION NUMBER	ACTION	CITE	EFFECTIVE DATE
Title 1. Administration			
1 VAC 55-10-10	Amended	20:5 VA.R. 454	12/17/03
1 VAC 55-10-20	Amended	20:5 VA.R. 454	12/17/03
1 VAC 55-10-30	Amended	20:5 VA.R. 454	12/17/03
1 VAC 55-20-320 emer	Amended	19:25 VA.R. 3829	10/1/03-9/30/04
Title 2. Agriculture			
2 VAC 20-30	Erratum	20:1 VA.R 39	--
Title 4. Conservation and Natural Resources			
4 VAC 15-30-40	Amended	19:25 VA.R. 3780	7/30/03
4 VAC 20-490-35	Added	20:6 VA.R. 584	11/1/03
4 VAC 20-490-40	Amended	20:6 VA.R. 584	11/1/03
4 VAC 20-490-45	Added	20:6 VA.R. 584	11/1/03
4 VAC 20-620-30	Amended	20:4 VA.R. 342	10/15/03
4 VAC 20-620-40	Amended	20:4 VA.R. 342	10/15/03
4 VAC 20-650-10 through 4 VAC 20-650-40	Amended	20:6 VA.R. 585	11/1/03
4 VAC 20-720-20	Amended	20:6 VA.R. 585	11/1/03
4 VAC 20-720-40	Amended	20:6 VA.R. 586	11/1/03
4 VAC 20-720-40 through 4 VAC 20-720-80	Amended	20:4 VA.R. 344-346	10/8/03
4 VAC 20-720-50 through 4 VAC 20-720-90	Amended	20:6 VA.R. 587-588	11/1/03
4 VAC 20-752-20	Amended	19:25 VA.R. 3780	7/23/03
4 VAC 20-950-46	Amended	20:6 VA.R. 589	11/1/03
4 VAC 20-950-47	Amended	20:6 VA.R. 589	11/1/03
4 VAC 20-950-48	Amended	20:6 VA.R. 589	11/1/03
4 VAC 20-1070-10 through 4 VAC 20-1070-50	Added	19:25 VA.R. 3781	8/1/03
4 VAC 25-31 (Forms)	Amended	20:2 VA.R. 135	--
4 VAC 25-31 (Forms)	Amended	20:5 VA.R. 487	--
4 VAC 25-130 (Forms)	Amended	20:1 VA.R 33	--
Title 6. Criminal Justice and Corrections			
6 VAC 20-171-10	Amended	20:3 VA.R. 214	11/19/03
6 VAC 20-171-20	Amended	20:3 VA.R. 217	11/19/03
6 VAC 20-171-30	Amended	20:3 VA.R. 217	11/19/03
6 VAC 20-171-40	Repealed	20:3 VA.R. 217	11/19/03
6 VAC 20-171-50 through 6 VAC 20-171-130	Amended	20:3 VA.R. 217-221	11/19/03
6 VAC 20-171-140	Repealed	20:3 VA.R. 221	11/19/03
6 VAC 20-171-150	Repealed	20:3 VA.R. 222	11/19/03
6 VAC 20-171-170 through 6 VAC 20-171-200	Amended	20:3 VA.R. 222-223	11/19/03
6 VAC 20-171-220	Amended	20:3 VA.R. 224	11/19/03
6 VAC 20-171-230	Amended	20:3 VA.R. 225	11/19/03
6 VAC 20-171-240	Amended	20:3 VA.R. 226	11/19/03
6 VAC 20-171-250 through 6 VAC 20-171-280	Amended	20:3 VA.R. 227-229	11/19/03
6 VAC 20-171-300	Amended	20:3 VA.R. 230	11/19/03
6 VAC 20-171-310	Amended	20:3 VA.R. 231	11/19/03
6 VAC 20-171-320	Amended	20:3 VA.R. 232	11/19/03
6 VAC 20-171-325	Repealed	20:3 VA.R. 233	11/19/03

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6 VAC 20-171-330	Repealed	20:3 VA.R. 233	11/19/03
6 VAC 20-171-340	Repealed	20:3 VA.R. 233	11/19/03
6 VAC 20-171-350 through 6 VAC 20-171-400	Amended	20:3 VA.R. 234-241	11/19/03
6 VAC 20-171-420	Amended	20:3 VA.R. 241	11/19/03
6 VAC 20-171-430	Amended	20:3 VA.R. 241	11/19/03
6 VAC 20-171-440	Amended	20:3 VA.R. 241	11/19/03
6 VAC 20-171-460	Amended	20:3 VA.R. 241	11/19/03
6 VAC 20-171-480	Amended	20:3 VA.R. 241	11/19/03
6 VAC 20-171-500	Amended	20:3 VA.R. 241	11/19/03
6 VAC 20-171-510	Amended	20:3 VA.R. 241	11/19/03
6 VAC 20-171-540	Amended	20:3 VA.R. 241	11/19/03
6 VAC 20-171-560	Amended	20:3 VA.R. 241	11/19/03
6 VAC 20-190-10	Amended	20:4 VA.R. 346	12/3/03
6 VAC 20-190-40	Amended	20:4 VA.R. 347	12/3/03
6 VAC 20-190-60	Amended	20:4 VA.R. 347	12/3/03
6 VAC 20-190-90	Amended	20:4 VA.R. 347	12/3/03
6 VAC 20-190-100	Amended	20:4 VA.R. 347	12/3/03
6 VAC 20-190-120	Amended	20:4 VA.R. 347	12/3/03
6 VAC 20-190-150	Amended	20:4 VA.R. 348	12/3/03
6 VAC 20-190-160	Amended	20:4 VA.R. 348	12/3/03
6 VAC 20-190-170	Amended	20:4 VA.R. 348	12/3/03
6 VAC 20-200	Repealed	20:4 VA.R. 348	12/3/03
6 VAC 20-220-10 through 6 VAC 20-220-80	Added	20:4 VA.R. 348-350	12/3/03
Title 8. Education			
8 VAC 20-70-10	Amended	20:7 VA.R. 656	1/14/04
8 VAC 20-70-30	Amended	20:7 VA.R. 657	1/14/04
8 VAC 20-70-40	Amended	20:7 VA.R. 657	1/14/04
8 VAC 20-70-70	Amended	20:7 VA.R. 657	1/14/04
8 VAC 20-70-80	Amended	20:7 VA.R. 657	1/14/04
8 VAC 20-70-100 through 8 VAC 20-70-170	Amended	20:7 VA.R. 657-658	1/14/04
8 VAC 20-70-190	Amended	20:7 VA.R. 658	1/14/04
8 VAC 20-70-200	Amended	20:7 VA.R. 658	1/14/04
8 VAC 20-70-210	Amended	20:7 VA.R. 658	1/14/04
8 VAC 20-70-220	Amended	20:7 VA.R. 658	1/14/04
8 VAC 20-70-230	Amended	20:7 VA.R. 658	1/14/04
8 VAC 20-70-235	Added	20:7 VA.R. 658	1/14/04
8 VAC 20-70-240 through 8 VAC 20-70-270	Repealed	20:7 VA.R. 658	1/14/04
8 VAC 20-70-280	Amended	20:7 VA.R. 658	1/14/04
8 VAC 20-70-290	Amended	20:7 VA.R. 659	1/14/04
8 VAC 20-70-300	Amended	20:7 VA.R. 659	1/14/04
8 VAC 20-70-340 through 8 VAC 20-70-380	Amended	20:7 VA.R. 659-660	1/14/04
8 VAC 20-70-390	Repealed	20:7 VA.R. 660	1/14/04
8 VAC 20-70-400 through 8 VAC 20-70-440	Amended	20:7 VA.R. 660	1/14/04
8 VAC 20-70-460	Amended	20:7 VA.R. 660	1/14/04
8 VAC 20-70-470	Amended	20:7 VA.R. 660	1/14/04
8 VAC 20-70-510	Amended	20:7 VA.R. 660	1/14/04
8 VAC 20-70-520	Repealed	20:7 VA.R. 660	1/14/04
8 VAC 20-70-525	Added	20:7 VA.R. 660	1/14/04
8 VAC 20-70-530 through 8 VAC 20-70-1510	Repealed	20:7 VA.R. 660	1/14/04
8 VAC 20-680-10 emer	Added	20:7 VA.R. 675	11/7/03-11/6/04
Title 9. Environment			
9 VAC 5-10-20	Amended	20:6 VA.R. 590	1/1/04
9 VAC 5-40	Erratum	19:25 VA.R. 3844	--
9 VAC 20-60-18	Amended	20:2 VA.R. 128	11/5/03
9 VAC 20-80	Erratum	19:26 VA.R. 3926	--
9 VAC 20-80-10	Amended	19:25 VA.R. 3782	9/24/03

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9 VAC 20-80-60	Amended	19:25 VA.R. 3782	9/24/03
9 VAC 20-80-80	Amended	19:25 VA.R. 3782	9/24/03
9 VAC 20-80-90	Amended	19:25 VA.R. 3782	9/24/03
9 VAC 20-80-100	Amended	19:25 VA.R. 3782	9/24/03
9 VAC 20-80-105	Added	19:25 VA.R. 3782	9/24/03
9 VAC 20-80-110	Amended	19:25 VA.R. 3782	9/24/03
9 VAC 20-80-113	Amended	19:25 VA.R. 3782	9/24/03
9 VAC 20-80-115	Amended	19:25 VA.R. 3782	9/24/03
9 VAC 20-80-120	Amended	19:25 VA.R. 3782	9/24/03
9 VAC 20-80-140	Amended	19:25 VA.R. 3782	9/24/03
9 VAC 20-80-150	Amended	19:25 VA.R. 3782	9/24/03
9 VAC 20-80-160	Amended	19:25 VA.R. 3782	9/24/03
9 VAC 20-80-170	Amended	19:25 VA.R. 3782	9/24/03
9 VAC 20-80-180	Amended	19:25 VA.R. 3782	9/24/03
9 VAC 20-80-190	Amended	19:25 VA.R. 3782	9/24/03
9 VAC 20-80-205	Added	19:25 VA.R. 3782	9/24/03
9 VAC 20-80-210	Amended	19:25 VA.R. 3782	9/24/03
9 VAC 20-80-240	Amended	19:25 VA.R. 3782	9/24/03
9 VAC 20-80-250	Amended	19:25 VA.R. 3782	9/24/03
9 VAC 20-80-260	Amended	19:25 VA.R. 3782	9/24/03
9 VAC 20-80-270	Amended	19:25 VA.R. 3782	9/24/03
9 VAC 20-80-280	Amended	19:25 VA.R. 3782	9/24/03
9 VAC 20-80-300	Amended	19:25 VA.R. 3782	9/24/03
9 VAC 20-80-310	Amended	19:25 VA.R. 3782	9/24/03
9 VAC 20-80-330	Amended	19:25 VA.R. 3782	9/24/03
9 VAC 20-80-340	Amended	19:25 VA.R. 3782	9/24/03
9 VAC 20-80-360	Amended	19:25 VA.R. 3782	9/24/03
9 VAC 20-80-370	Amended	19:25 VA.R. 3782	9/24/03
9 VAC 20-80-460	Amended	19:25 VA.R. 3782	9/24/03
9 VAC 20-80-485	Amended	19:25 VA.R. 3782	9/24/03
9 VAC 20-80-500	Amended	19:25 VA.R. 3782	9/24/03
9 VAC 20-80-510	Amended	19:25 VA.R. 3782	9/24/03
9 VAC 20-80-520	Amended	19:25 VA.R. 3782	9/24/03
9 VAC 20-80-530	Amended	19:25 VA.R. 3782	9/24/03
9 VAC 20-80-550	Amended	19:25 VA.R. 3782	9/24/03
9 VAC 20-80-570	Amended	19:25 VA.R. 3782	9/24/03
9 VAC 20-80-580	Amended	19:25 VA.R. 3782	9/24/03
9 VAC 20-80-600	Repealed	19:25 VA.R. 3782	9/24/03
9 VAC 20-80-620	Amended	19:25 VA.R. 3782	9/24/03
9 VAC 20-80-640	Added	19:25 VA.R. 3782	9/24/03
9 VAC 20-80-650	Added	19:25 VA.R. 3782	9/24/03
9 VAC 20-80-670	Amended	19:25 VA.R. 3782	9/24/03
9 VAC 20-80-730	Amended	19:25 VA.R. 3782	9/24/03
9 VAC 20-80-740	Amended	19:25 VA.R. 3782	9/24/03
9 VAC 20-80-760	Amended	19:25 VA.R. 3782	9/24/03
9 VAC 20-80-770	Repealed	19:25 VA.R. 3782	9/24/03
9 VAC 20-80-780	Amended	19:25 VA.R. 3782	9/24/03
9 VAC 20-80-790	Amended	19:25 VA.R. 3782	9/24/03
9 VAC 20-170-70	Added	20:3 VA.R. 242	11/19/03
9 VAC 20-170-195	Added	20:3 VA.R. 243	11/19/03
9 VAC 25-260	Erratum	19:26 VA.R. 3926	--
9 VAC 25-260-5 through 9 VAC 25-260-30	Amended	19:25 VA.R. 3785	¹
9 VAC 25-260-50	Amended	19:25 VA.R. 3785	¹
9 VAC 25-260-140	Amended	19:25 VA.R. 3785	¹

¹ 30 days after notice of EPA approval published in the Virginia Register of Regulations.

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SECTION NUMBER	ACTION	CITE	EFFECTIVE DATE
9 VAC 25-260-150	Repealed	19:25 VA.R. 3785	†
9 VAC 25-260-170	Amended	19:25 VA.R. 3785	†
9 VAC 25-260-190 through 9 VAC 25-260-240	Repealed	19:25 VA.R. 3785	†
9 VAC 25-260-300	Amended	19:25 VA.R. 3785	†
9 VAC 25-260-310	Amended	19:25 VA.R. 3785	†
9 VAC 25-260-320	Amended	19:25 VA.R. 3785	†
9 VAC 25-260-340	Repealed	19:25 VA.R. 3785	†
9 VAC 25-260-380 through 9 VAC 25-260-450	Amended	19:25 VA.R. 3785	†
9 VAC 25-260-415	Added	19:25 VA.R. 3785	†
9 VAC 25-260-470 through 9 VAC 25-260-540	Amended	19:25 VA.R. 3785	†
9 VAC 25-280-10 through 9 VAC 25-280-90	Added	19:25 VA.R. 3785	†
Title 10. Finance and Financial Institutions			
10 VAC 5-200-90	Added	20:2 VA.R. 128	9/11/03
Title 11. Gaming			
11 VAC 10-20-410 through 11 VAC 10-20-417 emer	Added	19:26 VA.R. 3913-3919	8/13/03-8/12/04
11 VAC 10-130-77	Amended	20:4 VA.R. 350	10/14/03
11 VAC 10-150-130	Amended	20:4 VA.R. 351	11/17/03
Title 12. Health			
12 VAC 5-218-10 through 12 VAC 5-218-60	Added	19:26 VA.R. 3911	10/8/03
12 VAC 5-220-200	Amended	20:2 VA.R. 129	11/5/03
12 VAC 5-400-10 through 12 VAC 5-400-90	Repealed	20:6 VA.R. 597	12/31/03
12 VAC 5-407-10 through 12 VAC 5-407-120	Added	19:26 VA.R. 3911	10/8/03
12 VAC 5-550-5	Added	19:26 VA.R. 3912	10/8/03
12 VAC 5-550-10	Repealed	19:26 VA.R. 3912	10/8/03
12 VAC 5-550-30	Amended	19:26 VA.R. 3912	10/8/03
12 VAC 5-550-40	Repealed	19:26 VA.R. 3912	10/8/03
12 VAC 5-550-70	Amended	19:26 VA.R. 3912	10/8/03
12 VAC 5-550-90 through 12 VAC 5-550-120	Amended	19:26 VA.R. 3912	10/8/03
12 VAC 5-550-125	Added	19:26 VA.R. 3912	10/8/03
12 VAC 5-550-130	Amended	19:26 VA.R. 3912	10/8/03
12 VAC 5-550-140	Amended	19:26 VA.R. 3912	10/8/03
12 VAC 5-550-150	Amended	19:26 VA.R. 3912	10/8/03
12 VAC 5-550-190	Amended	19:26 VA.R. 3912	10/8/03
12 VAC 5-550-200	Amended	19:26 VA.R. 3912	10/8/03
12 VAC 5-550-210	Amended	19:26 VA.R. 3912	10/8/03
12 VAC 5-550-230 through 12 VAC 5-550-260	Amended	19:26 VA.R. 3912	10/8/03
12 VAC 5-550-280 through 12 VAC 5-550-330	Amended	19:26 VA.R. 3912	10/8/03
12 VAC 5-550-350 through 12 VAC 5-550-410	Amended	19:26 VA.R. 3912	10/8/03
12 VAC 5-550-430 through 12 VAC 5-550-470	Amended	19:26 VA.R. 3912	10/8/03
12 VAC 5-550-510	Amended	19:26 VA.R. 3912	10/8/03
12 VAC 5-550-520	Amended	19:26 VA.R. 3912	10/8/03
12 VAC 30-40-100	Amended	20:4 VA.R. 351	12/3/03
12 VAC 30-40-140	Amended	20:4 VA.R. 351	12/3/03
12 VAC 30-40-240	Amended	20:4 VA.R. 351	12/3/03
12 VAC 30-40-280	Amended	20:4 VA.R. 351	12/3/03
12 VAC 30-40-290	Amended	20:4 VA.R. 351	12/3/03
12 VAC 30-50-10	Amended	20:1 VA.R. 25	10/22/03
12 VAC 30-50-20	Amended	20:1 VA.R. 26	10/22/03
12 VAC 30-50-50	Amended	20:1 VA.R. 26	10/22/03
12 VAC 30-50-60	Amended	20:1 VA.R. 27	10/22/03
12 VAC 30-50-120	Amended	20:1 VA.R. 27	10/22/03
12 VAC 30-50-130	Amended	20:7 VA.R. 661	2/1/04
12 VAC 30-50-140	Amended	20:1 VA.R. 27	10/22/03
12 VAC 30-50-140	Amended	20:1 VA.R. 29	10/22/03
12 VAC 30-50-150	Amended	20:1 VA.R. 30	10/22/03

Cumulative Table of VAC Sections Adopted, Amended, or Repealed

SECTION NUMBER	ACTION	CITE	EFFECTIVE DATE
12 VAC 30-50-530	Amended	20:1 VA.R. 28	10/22/03
12 VAC 30-50-226	Amended	20:7 VA.R. 661	2/1/04
12 VAC 30-50-420	Amended	20:7 VA.R. 664	2/1/04
12 VAC 30-50-430	Amended	20:7 VA.R. 664	2/1/04
12 VAC 30-50-510	Amended	20:7 VA.R. 667	2/1/04
12 VAC 30-60-61	Amended	20:7 VA.R. 669	2/1/04
12 VAC 30-60-143	Amended	20:7 VA.R. 669	2/1/04
12 VAC 30-60-147	Amended	20:7 VA.R. 673	2/1/04
12 VAC 30-70-201	Amended	20:5 VA.R. 455	1/4/04
12 VAC 30-70-291 emer	Amended	19:26 VA.R. 3920	8/13/03-8/12/04
12 VAC 30-70-301 emer	Amended	19:26 VA.R. 3921	8/13/03-8/12/04
12 VAC 30-70-331 emer	Amended	19:26 VA.R. 3922	8/13/03-8/12/04
12 VAC 30-80-40	Amended	20:2 VA.R. 132	11/6/03
12 VAC 30-120-700	Amended	19:25 VA.R. 3786	10/1/03
12 VAC 30-120-710	Amended	19:25 VA.R. 3789	10/1/03
12 VAC 30-120-720	Amended	19:25 VA.R. 3789	10/1/03
12 VAC 30-130-550	Repealed	20:7 VA.R. 673	2/1/04
12 VAC 30-130-565	Amended	20:7 VA.R. 673	2/1/04
12 VAC 30-130-570	Repealed	20:7 VA.R. 673	2/1/04
12 VAC 30-135-10 through 12 VAC 30-135-90	Added	19:25 VA.R. 3789-3791	10/1/03
12 VAC 35-105	Erratum	19:25 VA. R. 3844	--
Title 13. Housing			
13 VAC 5-21-10	Amended	19:25 VA.R. 3791	10/1/03
13 VAC 5-21-20	Amended	19:25 VA.R. 3792	10/1/03
13 VAC 5-21-31	Amended	19:25 VA.R. 3792	10/1/03
13 VAC 5-21-41	Amended	19:25 VA.R. 3793	10/1/03
13 VAC 5-21-51	Amended	19:25 VA.R. 3795	10/1/03
13 VAC 5-21-61	Amended	19:25 VA.R. 3795	10/1/03
13 VAC 5-21-70	Amended	19:25 VA.R. 3796	10/1/03
13 VAC 5-31-10	Amended	19:25 VA.R. 3796	10/1/03
13 VAC 5-31-40	Amended	19:25 VA.R. 3796	10/1/03
13 VAC 5-31-50	Amended	19:25 VA.R. 3796	10/1/03
13 VAC 5-31-60	Amended	19:25 VA.R. 3796	10/1/03
13 VAC 5-31-90	Amended	19:25 VA.R. 3796	10/1/03
13 VAC 5-31-110	Amended	19:25 VA.R. 3797	10/1/03
13 VAC 5-31-180	Amended	19:25 VA.R. 3797	10/1/03
13 VAC 5-31-190	Added	19:25 VA.R. 3797	10/1/03
13 VAC 5-51	Erratum	20:1 VA.R 39	--
13 VAC 5-51-11	Amended	19:25 VA.R. 3798	10/1/03
13 VAC 5-51-21	Amended	19:25 VA.R. 3798	10/1/03
13 VAC 5-51-31	Amended	19:25 VA.R. 3799	10/1/03
13 VAC 5-51-41	Amended	19:25 VA.R. 3799	10/1/03
13 VAC 5-51-51	Amended	19:25 VA.R. 3800	10/1/03
13 VAC 5-51-61	Amended	19:25 VA.R. 3801	10/1/03
13 VAC 5-51-71	Repealed	19:25 VA.R. 3801	10/1/03
13 VAC 5-51-81	Amended	19:25 VA.R. 3802	10/1/03
13 VAC 5-51-85	Added	19:25 VA.R. 3810	10/1/03
13 VAC 5-51-91	Amended	19:25 VA.R. 3812	10/1/03
13 VAC 5-51-101	Amended	19:25 VA.R. 3813	10/1/03
13 VAC 5-51-111	Amended	19:25 VA.R. 3814	10/1/03
13 VAC 5-51-121	Amended	19:25 VA.R. 3814	10/1/03
13 VAC 5-51-129	Added	19:25 VA.R. 3815	10/1/03
13 VAC 5-51-130	Amended	19:25 VA.R. 3815	10/1/03
13 VAC 5-51-131	Amended	19:25 VA.R. 3815	10/1/03
13 VAC 5-51-132	Added	19:25 VA.R. 3816	10/1/03

Cumulative Table of VAC Sections Adopted, Amended, or Repealed

SECTION NUMBER	ACTION	CITE	EFFECTIVE DATE
13 VAC 5-51-133	Amended	19:25 VA.R. 3816	10/1/03
13 VAC 5-51-135	Amended	19:25 VA.R. 3816	10/1/03
13 VAC 5-51-136	Amended	19:25 VA.R. 3817	10/1/03
13 VAC 5-51-140	Amended	19:25 VA.R. 3817	10/1/03
13 VAC 5-51-150	Amended	19:25 VA.R. 3818	10/1/03
13 VAC 5-51-155	Added	19:25 VA.R. 3822	10/1/03
13 VAC 5-51-160	Repealed	19:25 VA.R. 3822	10/1/03
13 VAC 5-51-170	Repealed	19:25 VA.R. 3822	10/1/03
13 VAC 5-51-180	Repealed	19:25 VA.R. 3823	10/1/03
13 VAC 5-51-181	Repealed	19:25 VA.R. 3823	10/1/03
13 VAC 5-51-182	Repealed	19:25 VA.R. 3824	10/1/03
13 VAC 5-51-190	Repealed	19:25 VA.R. 3824	10/1/03
13 VAC 5-51-200	Repealed	19:25 VA.R. 3824	10/1/03
13 VAC 5-61-11 through 13 VAC 5-61-460	Repealed	19:25 VA.R. 3824	10/1/03
13 VAC 5-62	Erratum	20:2 VA.R. 140	--
13 VAC 5-62-10 through 13 VAC 5-62-480	Added	19:25 VA.R. 3824	10/1/03
13 VAC 5-62-260 L	Suspended	20:2 VA.R. 133	²
13 VAC 5-62-260 M	Suspended	20:2 VA.R. 133	²
13 VAC 5-62-260 N	Suspended	20:2 VA.R. 133	²
13 VAC 5-80-10	Amended	19:25 VA.R. 3796	10/1/03
13 VAC 5-80-20	Repealed	19:25 VA.R. 3796	10/1/03
13 VAC 5-80-30	Repealed	19:25 VA.R. 3796	10/1/03
13 VAC 5-80-40 through 13 VAC 5-80-140	Amended	19:25 VA.R. 3796	10/1/03
13 VAC 5-80-150	Repealed	19:25 VA.R. 3796	10/1/03
13 VAC 5-91-10	Amended	19:25 VA.R. 3825	10/1/03
13 VAC 5-91-40	Amended	19:25 VA.R. 3825	10/1/03
13 VAC 5-91-50	Amended	19:25 VA.R. 3825	10/1/03
13 VAC 5-91-60	Amended	19:25 VA.R. 3825	10/1/03
13 VAC 5-91-100	Amended	19:25 VA.R. 3825	10/1/03
13 VAC 5-91-110	Amended	19:25 VA.R. 3825	10/1/03
13 VAC 5-91-120	Amended	19:25 VA.R. 3825	10/1/03
13 VAC 5-91-140	Amended	19:25 VA.R. 3825	10/1/03
13 VAC 5-91-160	Amended	19:25 VA.R. 3825	10/1/03
13 VAC 5-91-180	Amended	19:25 VA.R. 3826	10/1/03
13 VAC 5-91-200	Amended	19:25 VA.R. 3826	10/1/03
13 VAC 5-91-210	Amended	19:25 VA.R. 3826	10/1/03
13 VAC 5-91-230	Repealed	19:25 VA.R. 3826	10/1/03
13 VAC 5-91-245	Added	19:25 VA.R. 3826	10/1/03
13 VAC 5-91-250	Amended	19:25 VA.R. 3826	10/1/03
13 VAC 5-91-260	Amended	19:25 VA.R. 3826	10/1/03
13 VAC 5-91-270	Amended	19:25 VA.R. 3826	10/1/03
13 VAC 10-10-10	Amended	19:25 VA.R. 3826	8/1/03
13 VAC 10-10-20	Amended	19:25 VA.R. 3826	8/1/03
13 VAC 10-40-10	Amended	19:25 VA.R. 3827	8/1/03
13 VAC 10-40-30 through 13 VAC 10-40-70	Amended	19:25 VA.R. 3827	8/1/03
13 VAC 10-40-90	Amended	19:25 VA.R. 3827	8/1/03
13 VAC 10-40-100	Amended	19:25 VA.R. 3827	8/1/03
13 VAC 10-40-120	Amended	19:25 VA.R. 3827	8/1/03
13 VAC 10-40-120	Amended	20:3 VA.R. 244	9/25/03
13 VAC 10-40-130	Amended	19:25 VA.R. 3827	8/1/03
13 VAC 10-40-130	Amended	20:3 VA.R. 244	9/25/03
13 VAC 10-40-140	Amended	19:25 VA.R. 3827	8/1/03
13 VAC 10-40-160	Amended	19:25 VA.R. 3827	8/1/03

² Effective date suspended for further public comment.

Cumulative Table of VAC Sections Adopted, Amended, or Repealed

SECTION NUMBER	ACTION	CITE	EFFECTIVE DATE
13 VAC 10-40-160	Amended	20:3 VA.R. 244	9/25/03
13 VAC 10-40-170	Amended	19:25 VA.R. 3827	8/1/03
13 VAC 10-40-190 through 13 VAC 10-40-230	Amended	19:25 VA.R. 3827	8/1/03
13 VAC 10-40-190	Amended	20:3 VA.R. 244	9/25/03
13 VAC 10-40-210	Amended	20:3 VA.R. 244	9/25/03
13 VAC 10-40-230	Amended	20:3 VA.R. 244	9/25/03
Title 14. Insurance			
14 VAC 5-71-10	Amended	20:5 VA.R. 457	11/1/03
14 VAC 5-71-20	Amended	20:5 VA.R. 458	11/1/03
14 VAC 5-71-30	Repealed	20:5 VA.R. 459	11/1/03
14 VAC 5-71-31	Added	20:5 VA.R. 460	11/1/03
14 VAC 5-71-35	Added	20:5 VA.R. 463	11/1/03
14 VAC 5-71-40	Amended	20:5 VA.R. 464	11/1/03
14 VAC 5-71-60	Amended	20:5 VA.R. 464	11/1/03
14 VAC 5-71-70	Amended	20:5 VA.R. 465	11/1/03
14 VAC 5-71-80	Repealed	20:5 VA.R. 466	11/1/03
14 VAC 5-71-90	Amended	20:5 VA.R. 466	11/1/03
14 VAC 5-71-91	Added	20:5 VA.R. 467	11/1/03
14 VAC 5-71-92	Added	20:5 VA.R. 467	11/1/03
14 VAC 5-71-93	Added	20:5 VA.R. 467	11/1/03
14 VAC 5-310-10	Amended	20:5 VA.R. 469	12/31/03
14 VAC 5-310-20	Amended	20:5 VA.R. 469	12/31/03
14 VAC 5-310-30	Amended	20:5 VA.R. 469	12/31/03
14 VAC 5-310-40	Amended	20:5 VA.R. 470	12/31/03
14 VAC 5-310-50	Amended	20:5 VA.R. 470	12/31/03
14 VAC 5-310-60	Repealed	20:5 VA.R. 472	12/31/03
14 VAC 5-310-70	Repealed	20:5 VA.R. 473	12/31/03
14 VAC 5-310-80	Amended	20:5 VA.R. 475	12/31/03
14 VAC 5-310-90	Amended	20:5 VA.R. 479	12/31/03
14 VAC 5-310-100	Amended	20:5 VA.R. 481	12/31/03
14 VAC 5-310-105	Added	20:5 VA.R. 482	12/31/03
14 VAC 5-310-110	Repealed	20:5 VA.R. 482	12/31/03
Title 16. Labor and Employment			
16 VAC 25-85-1904.12	Repealed	20:7 VA.R. 673	1/15/04
16 VAC 25-85-1904.29	Amended	20:7 VA.R. 673	1/15/04
Title 18. Professional and Occupational Licensing			
18 VAC 15-30	Erratum	19:26 VA.R. 3926	--
18 VAC 76-40-10 emer	Added	19:25 VA.R. 3831	8/6/03-8/5/04
18 VAC 76-40-20 emer	Added	19:25 VA.R. 3831	8/6/03-8/5/04
18 VAC 76-40-30 emer	Added	19:25 VA.R. 3832	8/6/03-8/5/04
18 VAC 76-40-30 emer (Forms)	Added	19:25 VA.R. 3833	--
18 VAC 80-20-70	Amended	19:25 VA.R. 3827	10/1/03
Title 19. Public Safety			
19 VAC 30-20-80	Amended	20:4 VA.R. 352	1/2/04
19 VAC 30-80-20	Amended	20:2 VA.R. 134	11/5/03
19 VAC 30-80-40	Added	20:2 VA.R. 134	11/5/03
Title 21. Securities and Retail Franchising			
21 VAC 5-120-50	Amended	20:1 VA.R. 32	9/2/03
Title 22. Social Services			
22 VAC 30-20-90	Amended	20:7 VA.R. 674	1/15/04
22 VAC 40-705-60	Amended	20:5 VA.R. 483	1/1/04
22 VAC 40-705-130	Amended	20:5 VA.R. 483	1/1/04
22 VAC 40-730-115	Added	20:5 VA.R. 484	1/1/04
Title 24. Transportation and Motor Vehicles			
24 VAC 30-71	Erratum	20:7 VA.R. 678	--

Cumulative Table of VAC Sections Adopted, Amended, or Repealed

SECTION NUMBER	ACTION	CITE	EFFECTIVE DATE
24 VAC 30-71-10	Amended	20:4 VA.R. 353	12/3/03
24 VAC 30-71-20	Amended	20:4 VA.R. 353	12/3/03
24 VAC 30-71-30	Amended	20:4 VA.R. 354	12/3/03
24 VAC 30-71-50	Amended	20:4 VA.R. 354	12/3/03
24 VAC 30-71-70	Amended	20:4 VA.R. 354	12/3/03
24 VAC 30-71-80	Amended	20:4 VA.R. 354	12/3/03
24 VAC 30-71-90	Amended	20:4 VA.R. 355	12/3/03
24 VAC 30-71-100	Amended	20:4 VA.R. 355	12/3/03
24 VAC 30-71-110	Amended	20:4 VA.R. 355	12/3/03
24 VAC 30-71-120	Amended	20:4 VA.R. 355	12/3/03
24 VAC 30-71-130	Amended	20:4 VA.R. 355	12/3/03
24 VAC 30-71-150	Amended	20:4 VA.R. 357	12/3/03
24 VAC 30-71-160	Amended	20:4 VA.R. 357	12/3/03
24 VAC 30-71-170	Amended	20:4 VA.R. 362	12/3/03
24 VAC 30-580-10 through 24 VAC 30-580-40	Amended	20:5 VA.R. 485-486	10/28/03

PETITIONS FOR RULEMAKING

TITLE 18. PROFESSIONAL AND OCCUPATIONAL LICENSING

BOARD OF PHARMACY

Agency Decision

Title of Regulation: **18 VAC 110-20. Regulations Governing the Practice of Pharmacy.**

Statutory Authority: § 54.1-2400 and Chapters 33 (§ 54.1-3300 et seq.) and 34 (§ 54.1-3400 et seq.) of Title 54.1 of the Code of Virginia.

Name of Petitioner: Gregory C. Chase, RPh.

Nature of Petitioner's Request: Limit the time period on refills of Schedule VI drugs from two years to one year from date of issue for consistency with most other states and insurance plans and to reduce the number of invalid doctor/patient relationships after one year.

Agency Decision: Request Granted.

Statement of Reasons for Decision: The board voted to begin the process of amending regulations because the current regulation is in conflict with the policy of all third-party insurance companies that requires prescriptions to be renewed annually in order to be reimbursed. Approximately 85% of all prescriptions are covered by Medicaid or some other third-party. The disparity in requirements causes confusion on the part of patients who believe they have refills remaining, but the pharmacy cannot refill the prescription if third-party reimbursement is involved.

Agency Contact: Elaine J. Yeatts, Agency Regulatory Coordinator, Department of Health Professions, 6603 West Broad Street, Richmond, VA 23230-1712, telephone (804) 662-9918, FAX (804) 662-9114, or e-mail elaine.yeatts@dhp.state.va.us.

VA.R. Doc. No. R04-3; Filed December 2, 2003, 10:02 a.m.

NOTICES OF INTENDED REGULATORY ACTION

Symbol Key

† Indicates entries since last publication of the *Virginia Register*

TITLE 8. EDUCATION

STATE BOARD OF EDUCATION

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the State Board of Education intends to consider adopting regulations entitled **8 VAC 20-680, Regulations Governing the General Achievement Diploma**. The purpose of the regulation is to provide individuals with an additional diploma option. The regulation will specify requirements for the award of a general achievement diploma for those persons who have (i) achieved a passing score on the GED examination; (ii) successfully completed an education and training program designated by the Board of Education; and (iii) satisfied other requirements as may be established by the board for the award of such diploma. The regulations will replace emergency regulations adopted by the Board of Education in July 2003.

The agency intends to hold a public hearing on the proposed regulation after publication in the Virginia Register of Regulations.

Statutory Authority: §§ 22.1-253.13:4 and 22.1-254 of the Code of Virginia.

Public comments may be submitted until 5 p.m. on December 31, 2003.

Contact: Charles Finley, Assistant Superintendent for Accountability, Department of Education, P.O. Box 2120, Richmond, VA 23218-2120, telephone (804) 786-9421, FAX (804) 225-2524 or e-mail cfinley@mail.vak12ed.edu.

VA.R. Doc. No. R04-31; Filed November 7, 2003, 1:23 p.m.

TITLE 9. ENVIRONMENT

STATE WATER CONTROL BOARD

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the State Water Control Board intends to consider amending regulations entitled **9 VAC 25-260, Water Quality Standards**. The purpose of the proposed action is to include in the regulation updated numerical and narrative criteria to protect designated uses from the impacts of nutrients and sedimentation. The rulemaking will also include new and revised use designations for the Chesapeake Bay and its tidal tributaries.

The agency intends to hold a public hearing on the proposed action after publication in the Virginia Register of Regulations.

Statutory Authority: §§ 62.1-44.15 and 62.1-44.15 of the Code of Virginia, the Clean Water Act (33 USC § 1251 et seq.) and 40 CFR Part 131.

Public comments may be submitted until 5 p.m. on January 15, 2004.

Contact: Eleanore M. Daub, Department of Environmental Quality, P.O. Box 10009, Richmond, VA 23240, telephone (804) 698-4111, FAX (804) 698-4522 or e-mail emdaub@deq.state.va.us.

VA.R. Doc. No. R04-39; Filed October 29, 2003, 11:17 a.m.

TITLE 11. GAMING

STATE LOTTERY BOARD

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the State Lottery Board intends to consider amending regulations entitled **11 VAC 5-20, Administration Regulations**. The purpose of the proposed action is to update, streamline and add flexibility to the Virginia Lottery's procurement processes.

The agency does not intend to hold a public hearing on the proposed action after publication in the Virginia Register of Regulations.

Statutory Authority: § 58.1-4007 of the Code of Virginia.

Public comments may be submitted until 5 p.m. on January 16, 2004.

Contact: Betty K. Hill, Administrative Assistant, Division of Legislative and Regulatory Affairs, State Lottery Board, 900 E. Main St., Richmond, VA 23219, telephone (804) 692-7904, FAX (804) 692-7603 or e-mail bhill@valottery.state.va.us.

VA.R. Doc. No. R04-52; Filed November 24, 2003, 12:04 p.m.

TITLE 12. HEALTH

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

† Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the Department of Medical Assistance

Notices of Intended Regulatory Action

Services intends to consider amending regulations entitled **12 VAC 30-50, Amount, Duration, and Scope of Medical and Remedial Care Services, 12 VAC 30-80, Methods and Standards for Establishing Payment Rates: Other Types of Care, and 12 VAC 30-130, Amount, Duration and Scope of Selected Services.** The purpose of the proposed action is to institute the requirement that prescription drugs be contained within the DMAS preferred drug list in order to be covered by Medicaid. Drugs not included on this list will require prior authorization before they will be paid for by Medicaid. This action also establishes state supplemental rebates and the Pharmacy and Therapeutics Committee.

The agency does not intend to hold a public hearing on the proposed action after publication in the Virginia Register.

Statutory Authority: §§ 32.1-324 and 32.1-325 of the Code of Virginia.

Public comments may be submitted until January 28, 2004, to Adrienne Fegans, Health Programs Administrator, Department of Medical Assistance Services, 600 E. Broad St., Suite 1300, Richmond, VA 23219.

Contact: Victoria P. Simmons, Regulatory Coordinator, Department of Medical Assistance Services, 600 E. Broad St., Suite 1300, Richmond, VA 23219, telephone (804) 786-7959, FAX (804) 786-1680 or e-mail vsimmons@dmas.state.va.us.

VA.R. Doc. No. R04-54; Filed November 25, 2003, 3:44 p.m.

† Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the Department of Medical Assistance Services intends to consider amending regulations entitled **12 VAC 30-120, Waivered Services: MEDALLION.** The purpose of the proposed action is to fully conform the MEDALLION regulations (12 VAC 30-120-260 through 12 VAC 30-120-350) to requirements of the federal Balanced Budget Act of 1997, as well as to update the MEDALLION regulation with regard to the MEDALLION Waiver and changes in other regulations.

The agency does not intend to hold a public hearing on the proposed action after publication in the Virginia Register.

Statutory Authority: §§ 32.1-324 and 32.1-325 of the Code of Virginia.

Public comments may be submitted until January 28, 2004, to Alissa Nashwinter, Division of Health Care Services, Department of Medical Assistance Services, 600 E. Broad St., Suite 1300, Richmond, VA 23219.

Contact: Victoria P. Simmons, Regulatory Coordinator, Department of Medical Assistance Services, 600 E. Broad St., Suite 1300, Richmond, VA 23219, telephone (804) 786-7959, FAX (804) 786-1680 or e-mail vsimmons@dmas.state.va.us.

VA.R. Doc. No. R04-59; Filed December 4, 2003, 4:18 p.m.

† Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the Department of Medical Assistance Services intends to consider amending regulations entitled

12 VAC 30-120, Waivered Services: MEDALLION II. The purpose of the proposed action is to fully conform the MEDALLION II regulations (12 VAC 30-120-360 through 12 VAC 30-120-420) to requirements of the federal Balanced Budget Act of 1997, as well as to update the MEDALLION II regulation with regard to the MEDALLION II Waiver and changes in other regulations.

The agency does not intend to hold a public hearing on the proposed action after publication in the Virginia Register.

Statutory Authority: §§ 32.1-324 and 32.1-325 of the Code of Virginia.

Public comments may be submitted until January 28, 2004, to Patti Davidson, Division of Health Care Services, Department of Medical Assistance Services, 600 E. Broad St., Suite 1300, Richmond, VA 23219.

Contact: Victoria P. Simmons, Regulatory Coordinator, Department of Medical Assistance Services, 600 E. Broad St., Suite 1300, Richmond, VA 23219, telephone (804) 786-7959, FAX (804) 786-1680 or e-mail vsimmons@dmas.state.va.us.

VA.R. Doc. No. R04-60; Filed December 4, 2003, 4:20 p.m.

TITLE 18. PROFESSIONAL AND OCCUPATIONAL LICENSING

BOARDS OF NURSING AND MEDICINE

Notice of Intended Regulatory Action

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the Boards of Nursing and Medicine intend to consider amending regulations entitled **18 VAC 90-30, Regulations Governing the Licensure of Nurse Practitioners.** The purpose of the proposed action is to (i) state clearly that an applicant for initial licensure in a specialty area of practice must have a degree from an advanced practice educational program and certification by national examination that are both consistent with that area of practice; (ii) specify that a graduate degree is required for licensure; and (iii) write regulations for licensure by endorsement.

The agency intends to hold a public hearing on the proposed action after publication in the Virginia Register of Regulations.

Statutory Authority: §§ 54.1-2400 and 54.1-2957 of the Code of Virginia.

Public comments may be submitted until 5 p.m. on January 14, 2004.

Contact: Jay Douglas, R.N., Executive Director, Board of Nursing, 6603 W. Broad St., Richmond, VA 23230-1717, telephone (804) 662-9909, FAX (804) 662-9943 or e-mail jay.douglas@dhp.state.va.us.

VA.R. Doc. No. R04-49; Filed November 20, 2003, 2:28 p.m.

PROPOSED REGULATIONS

For information concerning Proposed Regulations, see Information Page.

Symbol Key

Roman type indicates existing text of regulations. *Italic type* indicates proposed new text.
Language which has been stricken indicates proposed text for deletion.

TITLE 12. HEALTH

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Titles of Regulations: **12 VAC 30-60. Standards Established and Methods Used to Assure High Quality of Care (amending 12 VAC 30-60-40 and 12 VAC 30-60-320).**

12 VAC 30-90. Methods and Standards for Establishing Payment Rates for Long-Term Care (amending 12 VAC 30-90-264).

Statutory Authority: §§ 32.1-324 and 32.1-325 of the Code of Virginia and Item 325 LLL of Chapter 1042 of the 2003 Acts of Assembly.

Public Hearing Date: N/A -- Public comments may be submitted until February 27, 2004.

(See Calendar of Events section for additional information)

Agency Contact: Paula Margolis, Reimbursement Analyst, Division of Provider Reimbursement, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 371-4767, FAX (804) 786-1680, or e-mail pmargolis@dmass.state.va.us.

Basis: Section 32.1-325 of the Code of Virginia grants to the Board of Medical Assistance Services (BMAS) the authority to administer and amend the Plan for Medical Assistance. Chapter 1042 of the 2003 Acts of Assembly, Item 325 LLL, states that: "The Department of Medical Assistance Services shall amend its State Plan for Medical Assistance governing Medicaid reimbursement for nursing facilities to eliminate coverage of rehabilitation services and complex care services from the Specialized Care program, except for pediatric Specialized Care and except for specialized Traumatic Brain Injury Units. The department shall amend the ventilator services component of the Specialized Care program to include individuals who have a tracheostomy and who meet certain additional criteria. The department shall clarify that continuous positive airway pressure and bilevel positive airway pressure, except for pediatric specialized care, are not included in ventilator services for Specialized Care."

Purpose: The purpose of this proposed action is to discontinue an additional layer of reimbursement for Specialized Care Services that became redundant when the agency adopted the Resource Utilization Groups (RUGs) reimbursement methodology for nursing facilities on July 1, 2002. This action does not discontinue the coverage of such specialized care services as they are already incorporated into the RUGs methodology. Therefore, this proposed action is not expected to have any affect on the health, safety, or welfare of the citizens of the Commonwealth or of Medicaid residents in nursing facilities.

Substance: In late 1991, DMAS implemented a new level of nursing facility (NF) reimbursement based on patient care intensity and level of service, called Specialized Care Services, in order to make additional payments to nursing facilities. At the time of this implementation the then-current NF reimbursement methodology did not adequately address the costs of caring for residents who required Specialized Care Services.

Specialized Care patients were initially organized into four categories, Comprehensive Rehabilitation, Complex Care, Ventilator Dependent, and AIDS. The goal of the Specialized Care payment system was to encourage NFs to provide services to residents who require more intense services. Nursing facilities operated separate Specialized Care units within regular nursing facilities in order to accommodate patients who met the criteria for Specialized Care Services.

On July 1, 2002, the Nursing Home Payment System: Resource Utilization Groups (NHPS: RUGS) method was implemented as the regular nursing home payment system; it replaced the Patient Intensity Rating System (PIRS). The NHPS: RUGS system is facility-specific and is designed to make payment appropriate for the intensity of care that meets the needs of residents by grouping patients according to the severity of their condition and the level of care they require. The prior PIRS methodology was only marginally sensitive to the intensity of care being received by Medicaid nursing facility residents.

With the implementation of NHPS: RUGS, reimbursement more accurately reflected the intensity of care NF residents require, and a separate, additional Specialized Care reimbursement payment was no longer needed. The Comprehensive Rehabilitation and Complex Care components of Specialized Care are included in the NHPS: RUGS method, making these two components redundant. These proposed regulations change the criteria and scope of services that are included in the Adult Specialized Care reimbursement rate group to exclude the Comprehensive Rehabilitation and Complex Care components. Providers will receive reimbursement that reflects the required level of patient care through the RUGS-III nursing home payment methodology for adults who meet the previous criteria for Comprehensive Rehabilitation Care and Complex Care.

For the few nursing facility residents who require mechanical ventilation and those who have a daily dependence on device-based respiratory support, DMAS proposes to continue the previous payment methodology. Children who meet the requirements for Pediatric Specialized Care and adults who require mechanical ventilation or who have a complex tracheostomy and meet additional criteria will continue to be included in Specialized Care.

Issues: The advantages of the proposed changes include increased access to nursing facilities by individuals who receive Medicaid and who require a higher intensity care. The

facilities that participate in Specialized Care will receive less in revenue under this revised Specialized Care system but can expect to see higher rates under the NHPS: RUGS system, commensurate with the movement of high intensity care patients from Specialized Care units to regular nursing facilities. There are no disadvantages to the public or the Commonwealth.

Department of Planning and Budget's Economic Impact Analysis: The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with § 2.2-4007 H of the Administrative Process Act and Executive Order Number 21 (02). Section 2.2-4007 H requires that such economic impact analyses include, but need not be limited to, the projected number of businesses or other entities to whom the regulation would apply, the identity of any localities and types of businesses or other entities particularly affected, the projected number of persons and employment positions to be affected, the projected costs to affected businesses or entities to implement or comply with the regulation, and the impact on the use and value of private property. The analysis presented below represents DPB's best estimate of these economic impacts.

Summary of the proposed regulation. Pursuant to Item 325 LLL of the 2003 Appropriation Act, the proposed changes will permanently eliminate additional reimbursement to nursing facilities for the complex and rehabilitation parts of specialized care services for adults. The proposed changes have been effective since July 2003 under the emergency regulations.

Estimated economic impact. Current language in the regulations provides additional reimbursement to nursing facilities for the higher cost of specialized care in addition to regular reimbursements. There are three categories of adult specialized services: rehabilitative care, complex care, and ventilation/tracheostomy. Residents with special medical needs require higher levels of care, which necessitated additional reimbursement to nursing homes providing specialized services prior to the implementation of Resource Utilization Groups (RUGs) reimbursement methodology in July 2002. Since RUGs methodology takes into account the intensity of care when determining reimbursement rates, the referenced statutory changes eliminated the additional reimbursement for the complex and rehabilitation parts of specialized care services to nursing facilities since July 2003 through the emergency regulations.¹

Compared to the previous reimbursement methodology, 22 nursing facilities providing specialized care services are estimated to receive approximately \$2 million less under the RUGs methodology for the same services provided. At the same time, the general fund savings for the Commonwealth is about one half of this amount. The estimated revenue losses amount to an 11% reduction in the total revenues received by all nursing facilities for specialized care services. The distribution of the revenue losses among the nursing homes, however, is not uniform as some facilities have more

specialized care residents than others and offsetting payments under RUGs methodology will be different.

While the reduction in reimbursements reduces incentives to provide this type of care, the significance of this effect and therefore the actual economic outcome depend on whether the new rates are sufficient to cover actual costs of specialized care and allow a profit margin. The Department of Medical Assistance Services indicates that the 2001 reimbursements were 14.23 percent above the actual costs across all facilities, believes that the new reduced rates are sufficient to cover the costs, and does not expect a significant effect on provision of these services. Several nursing facility administrators contacted by phone disagree. They indicated (i) the reduction in the rates is significant, (ii) the new rate is not sufficient to cover the costs of providing specialized care, (iii) some facilities will likely stop providing rehabilitation and complex care services, and (iv) these recipients may start being cared for in hospitals at a substantially higher cost. In particular, one of the nursing homes with multiple facilities in Virginia indicated that they no longer accept recipients needing comprehensive rehabilitation and complex care.

Businesses and entities affected. The proposed regulations affect nursing homes providing specialized care services. Currently, there are 22 such facilities in Virginia.

Localities particularly affected. The proposed regulations apply throughout the Commonwealth.

Projected impact on employment. If nursing homes stop providing rehabilitation and complex care services as a response to elimination of additional reimbursements for specialized care, the demand for medical personnel and staff at nursing homes would decrease. However, some of this decrease would be countered by increased demand for similar personnel at alternate special care facilities.

Effects on the use and value of private property. If the new cost-revenue structure significantly affects the future profit stream of nursing homes, their value would also be affected accordingly.

Agency's Response to the Department of Planning and Budget's Economic Impact Analysis: The agency has reviewed the Economic Impact Analysis prepared by the Department of Planning and Budget regarding the regulations concerning Discontinuing Additional Reimbursement for Adult Specialized Care Services (12 VAC 30-60 and 12 VAC 30-90). The agency raises no issues with this analysis.

Summary:

This action proposes to discontinue the additional reimbursement to nursing facilities (NFs) for the complex care and rehabilitation components of specialized care services for adults. Specialized care services are those services provided to NF residents who have special medical needs, such as comprehensive rehabilitation, complex care, ventilator dependence, and persons diagnosed with AIDS. Prior to the adoption of the current Resource Utilization Groups (RUGs) reimbursement methodology, additional reimbursement to NFs was deemed appropriate for the higher levels of care required by specific residents. Once the RUGs methodology was implemented, however,

¹ The additional reimbursement for mechanical ventilation and complex tracheostomy is retained because the RUGs methodology does not capture the additional costs of these specialized care services.

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additional reimbursement for comprehensive rehabilitation care and complex health care was no longer necessary as the RUGs system incorporated such additional care costs. The RUGs methodology does not address ventilator dependency and, therefore, it is being retained as a specially reimbursed category of specialized care services.

12 VAC 30-60-40. Utilization control: Nursing facilities.

A. Long-term care of residents in nursing facilities will be provided in accordance with federal law using practices and procedures that are based on the resident's medical and social needs and requirements. All nursing facility services, including specialized care, shall be provided in accordance with guidelines found in the Virginia Medicaid Nursing Home Manual.

B. Nursing facilities must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity. This assessment must be conducted no later than 14 days after the date of admission and promptly after a significant change in the resident's physical or mental condition. Each resident must be reviewed at least quarterly, and a complete assessment conducted at least annually.

C. The Department of Medical Assistance Services shall periodically conduct a validation survey of the assessments completed by nursing facilities to determine that services provided to the residents are medically necessary and that needed services are provided. The survey will be composed of a sample of Medicaid residents and will include review of both current and closed medical records.

D. Nursing facilities must submit to the Department of Medical Assistance Services resident assessment information at least every six months for utilization review. If an assessment completed by the nursing facility does not reflect accurately a resident's capability to perform activities of daily living and significant impairments in functional capacity, then reimbursement to nursing facilities may be adjusted during the next quarter's reimbursement review. Any individual who willfully and knowingly certifies (or causes another individual to certify) a material and false statement in a resident assessment is subject to civil money penalties.

E. In order for reimbursement to be made to the nursing facility for a recipient's care, the recipient must meet nursing facility criteria as described in 12 VAC 30-60-300 (Nursing facility criteria).

In order for reimbursement to be made to the nursing facility for a recipient requiring specialized care, the recipient must meet specialized care criteria as described in 12 VAC 30-60-320 (Adult *ventilation/tracheostomy* specialized care criteria) or 12 VAC 30-60-340 (Pediatric and adolescent specialized care criteria). Reimbursement for specialized care must be preauthorized by the Department of Medical Assistance Services. In addition, reimbursement to nursing facilities for residents requiring specialized care will only be made on a contractual basis. Further specialized care services requirements are set forth below.

In each case for which payment for nursing facility services is made under the State Plan, a physician must recommend at

the time of admission, or if later, the time at which the individual applies for medical assistance under the State Plan, that the individual requires nursing facility care.

F. For nursing facilities, a physician must approve a recommendation that an individual be admitted to a facility. The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. At the option of the physician, required visits after the initial visit may alternate between personal visits by the physician and visits by a physician assistant or nurse practitioner.

G. When the resident no longer meets nursing facility criteria or requires services that the nursing facility is unable to provide, then the resident must be discharged.

H. Specialized care services.

1. Providers must be nursing facilities certified by the Division of Licensure and Certification, State Department of Health, and must have a current signed participation agreement with the Department of Medical Assistance Services to provide nursing facility care. Providers must agree to provide care to at least four residents who meet the specialized care criteria for children/adolescents or adults.

2. Providers must be able to provide the following specialized services to Medicaid specialized care recipients:

a. Physician visits at least once weekly (after initial physician visit, subsequent visits may alternate between physician and physician assistant or nurse practitioner);

b. Skilled nursing services by a registered nurse available 24 hours a day;

c. Coordinated multidisciplinary team approach to meet the needs of the resident;

d. Infection control;

e. For residents under age 21 who require two of three rehabilitative services (physical therapy, occupational therapy, or speech-language pathology services), therapy services must be provided at a minimum of 90 minutes each day, five days per week;

~~f. For residents over age 21 who require two of three rehabilitative services (physical therapy, occupational therapy, or speech-language pathology services), therapy services must be provided at a minimum of two hours per day, five days a week;~~

~~g. f.~~ Ancillary services related to a plan of care;

~~h. g.~~ Respiratory therapy services by a board-certified therapist (for ventilator patients, these services must be available 24 hours per day);

~~i. h.~~ Psychology services by a licensed clinical psychologist, licensed clinical social worker, licensed professional counselor, or licensed clinical nurse specialist-psychiatric related to a plan of care;

~~j. i.~~ Necessary durable medical equipment and supplies as required by the plan of care;

- ~~k. j.~~ Nutritional elements as required;
- ~~l. k.~~ A plan to assure that specialized care residents have the same opportunity to participate in integrated nursing facility activities as other residents;
- ~~m. l.~~ Nonemergency transportation;
- ~~n. m.~~ Discharge planning; and
- ~~o. n.~~ Family or caregiver training.

3. Providers must coordinate with appropriate state and local agencies for educational and habilitative needs for Medicaid specialized care recipients who are under the age of 21.

12 VAC 30-60-320. Adult ventilation/tracheostomy specialized care criteria.

~~§ 2-0.~~ A. General description. The resident must have long-term health conditions requiring close medical supervision, 24 hour licensed nursing care, and specialized services or equipment.

~~§ 2-1. Targeted population.~~ B. *The targeted adult population requiring specialized care includes individuals requiring mechanical ventilation and individuals with a complex tracheostomy who require comprehensive respiratory therapy services.*

- ~~A. Individuals requiring mechanical ventilation~~
- ~~B. Individuals with communicable diseases requiring universal or respiratory precautions~~
- ~~C. Individuals requiring ongoing intravenous medication or nutrition administration~~
- ~~D. Individuals requiring comprehensive rehabilitative therapy services~~

~~§ 2-2.~~ C. Criteria.

- ~~A. 1.~~ The individual must require at a minimum:
 - ~~1. a.~~ Physician visits at least once weekly. (The initial physician visit must be made by the physician personally, and subsequent required physician visits after the initial visit may alternate between personal visits by the physician and visits by a physician assistant or nurse practitioner.)
 - ~~2. b.~~ Skilled nursing services 24 hours a day. (A registered nurse must be on the nursing unit on which the resident resides, 24 hours a day, whose sole responsibility is the designated unit).
 - ~~c.~~ Respiratory services provided by a licensed board-certified respiratory therapist (these services must be available 24 hours a day).
 - ~~3. d.~~ Coordinated multidisciplinary team approach to meet needs.
- ~~B. 2.~~ In addition, the individual must meet one of the following two requirements:
 - ~~1.~~ Must require two out of three of the following rehabilitative services: Physical Therapy, Occupational

~~Therapy, Speech pathology services; therapy must be provided at a minimum of 2 hours of therapy per day, 5 days per week; individual must demonstrate progress in overall rehabilitative plan of care on a monthly basis; or~~

~~2. Must require special equipment such as mechanical ventilators, respiratory therapy equipment (that has to be supervised by licensed nurse or respiratory therapist), monitoring device (respiratory or cardiac) kinetic therapy; or~~

~~3. Individuals that require at least one of the following special services:~~

- ~~a. Ongoing administration of intravenous medications of nutrition (i.e., TPN, antibiotic therapy, narcotic administration, etc.)~~
- ~~b. Special infection control precautions (universal or respiratory precaution; this does not include handwashing precautions only)~~
- ~~c. Dialysis treatment that is provided on unit (i.e., peritoneal dialysis)~~
- ~~d. Daily respiratory therapy treatments that must be provided by a skilled nurse or respiratory therapist~~
- ~~e. Extensive wound care requiring debridement, irrigation, packing, etc., more than two times a day (i.e., grade IV decubiti; large surgical wounds that cannot be closed, second or third degree burns covering more than 10% of the body)~~
- ~~f. Multiple unstable ostomies (a single ostomy does not constitute a requirement for special care) requiring frequent care (i.e., suctioning every hour, stabilization of feeding; stabilization of elimination)~~

- ~~a. Require a mechanical ventilator; or~~
- ~~b. Have a complex tracheostomy that meets all of the following criteria. The individual must:~~

- ~~(1) Have a tracheostomy, with the potential for weaning off of it, or documentation of attempts to wean, with subsequent inability to wean;~~
- ~~(2) Require nebulizer treatments followed by chest PT (physiotherapy) at least four times per day or nebulizer treatments at least four times a day, which must be provided by a licensed nurse or licensed respiratory therapist;~~
- ~~(3) Require pulse oximetry monitoring at least every shift due to demonstrated unstable oxygen saturation levels;~~
- ~~(4) Require respiratory assessment and documentation every shift by licensed respiratory therapist or trained nurse;~~
- ~~(5) Have a physician's order for oxygen therapy with documented usage;~~
- ~~(6) Require tracheostomy care at least daily;~~
- ~~(7) Have a physician's order for suctioning as needed; and~~

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(8) *Be deemed to be at risk of requiring subsequent mechanical ventilation.*

12 VAC 30-90-264. Specialized care services.

Specialized care services provided in conformance with 12 VAC 30-60-40 E and H, 12 VAC 30-60-320 and 12 VAC 30-60-340 shall be reimbursed under the following methodology. The nursing facilities that provide adult specialized care for the categories of Ventilator Dependent Care, ~~Comprehensive Rehabilitation Care, and Complex Health Care~~ will be placed in one group for rate determination. The nursing facilities that provide pediatric specialized care in a dedicated pediatric unit of eight beds or more will be placed in a second group for rate determination.

1. Routine operating cost. Routine operating cost shall be defined as in 12 VAC 30-90-271 and 12 VAC 30-90-272. To calculate the routine operating cost reimbursement rate, routine operating cost shall be converted to a per diem amount by dividing it by actual patient days.

2. Allowable cost identification and cost reimbursement limitations. The provisions of Article 5 (12 VAC 30-90-50 et seq.) of Subpart II of Part II of this chapter and of Appendix III (12 VAC 30-90-290) of Part III of this chapter shall apply to specialized care cost and reimbursement.

3. Routine operating cost rates. Each facility shall be reimbursed a prospective rate for routine operating costs. This rate will be the lesser of the facility-specific prospective routine operating ceiling, or the facility-specific prospective routine operating cost per day plus an efficiency incentive. This efficiency incentive shall be calculated by the same method as in 12 VAC 30-90-41.

4. Facility-specific prospective routine operating ceiling. Each nursing facility's prospective routine operating ceiling shall be calculated as:

a. Statewide ceiling. The statewide routine operating ceiling shall be the weighted average (weighted by 1994 days) of specialized care rates in effect on July 1, 1996, reduced by statewide weighted average ancillary and capital cost per day amounts based on audited 1994 cost data from the 12 facilities whose 1994 FY specialized care costs were audited during 1996. This routine operating ceiling amount shall be adjusted for inflation by the percentage of change in the moving average of the Virginia specific Skilled Nursing Facility Market Basket of Routine Service Costs, as developed by DRI/McGraw-Hill, using the second quarter 1996 DRI table. The respective statewide operating ceilings will be adjusted each quarter in which the provider's most recent fiscal year ends, by adjusting the most recent interim ceiling by 100% of historical inflation and 50% of forecasted inflation to the end of the provider's next fiscal year.

b. The portion of the statewide routine operating ceiling relating to nursing salaries (as determined by the 1994 audited cost report data, or 67.22%) will be wage adjusted using a normalized wage index. The normalized wage index shall be the wage index applicable to the individual provider's geographic location under Medicare rules of reimbursement for skilled nursing facilities,

divided by the statewide average of such wage indices across the state. This normalization of wage indices shall be updated January 1, after each time the Health Care Financing Administration (HCFA) publishes wage indices for skilled nursing facilities. Updated normalization shall be effective for fiscal years starting on and after the January 1 for which the normalization is calculated.

c. The percentage of the statewide routine operating ceiling relating to the nursing labor and nonlabor costs (as determined by the 1994 audited cost report data or 71.05%) will be adjusted by the nursing facility's specialized care average Resource Utilization Groups, Version III (RUG-III) Nursing-Only Normalized Case Mix Index (NCMI). The NCMI for each nursing facility will be based on all specialized care patient days rendered during the six-month period prior to that in which the ceiling applies (see subdivision 6 of this section).

5. Normalized case mix index (NCMI). Case mix shall be measured by RUG-III nursing-only index scores based on Minimum Data Set (MDS) data. The RUG-III nursing-only weights developed at the national level by the Health Care Financing Administration (HCFA) (see 12 VAC 30-90-320) shall be used to calculate a facility-specific case mix index (CMI). The facility-specific CMI, divided by the statewide CMI shall be the facility's NCMI. The steps in the calculation are as follows:

a. The facility-specific CMI for purposes of this rate calculation shall be the average of the national RUG-III Nursing-Only weights calculated across all patient days in the facility during the six months prior to the six-month period to which the NCMI shall be applied to the facility's routine operating cost and ceiling.

b. The statewide CMI for purposes of this rate calculation shall be the average of the national RUG-III Nursing-Only weights calculated across all specialized care patient days in all Specialized Care Nursing facilities in the state during the six months prior to the six-month period to which the NCMI shall be applied. A new statewide CMI shall be calculated for each six-month period for which a provider-specific rate must be set.

c. The facility-specific NCMI for purposes of this rate calculation shall be the facility-specific CMI from subdivision 5 a of this section divided by the statewide CMI from subdivision 5 b of this section.

d. Each facility's NCMI shall be updated semiannually, at the start and the midpoint of the facility's fiscal year.

e. Patient days for which the lowest RUG-III weight is imputed, as provided in subdivision 14 c of this section, shall not be included in the calculation of the NCMI.

6. Facility-specific prospective routine operating base cost per day: The facility-specific routine operating cost per day to be used in the calculation of the routine operating rate and the efficiency incentive shall be the actual routine cost per day from the most recent fiscal year's cost report, adjusted (using DRI-Virginia inflation factors) by 50% of historical inflation and 50% of the forecasted inflation, and adjusted for case mix as described below:

a. An NCMI rate adjustment shall be applied to each facility's prospective routine nursing labor and nonlabor operating base cost per day for each semiannual period of the facility's fiscal year.

b. The NCMI calculated for the second semiannual period of the previous fiscal year shall be divided by the average of that (previous) fiscal year's two semiannual NCMI's to yield an "NCMI cost rate adjustment" to the prospective nursing labor and nonlabor operating cost base rate in the first semiannual period of the subsequent fiscal year.

c. The NCMI determined in the first semiannual period of the subsequent fiscal year shall be divided by the average of the previous fiscal year's two semiannual NCMI's to determine the NCMI cost rate adjustment to the prospective nursing labor and nonlabor operating base cost per day in the second semiannual period of the subsequent fiscal year.

See 12 VAC 30-90-310 for an illustration of how the NCMI is used to adjust routine operating cost ceilings and semiannual NCMI adjustments to the prospective routine operating base cost rates.

7. Interim rates. Interim rates, for processing claims during the year, shall be calculated from the most recent settled cost report and Minimum Data Set (MDS) data available at the time the interim rates must be set, except that failure to submit cost and MDS data timely may result in adjustment to interim rates as provided elsewhere.

8. Ancillary costs. Specialized care ancillary costs will be paid on a pass-through basis for those Medicaid specialized care patients who do not have Medicare or any other sufficient third-party insurance coverage. Ancillary costs will be reimbursed as follows:

a. All covered ancillary services, except kinetic therapy devices, will be reimbursed for reasonable costs as defined in the current NHPS. See 12 VAC 30-90-290 for the cost reimbursement limitations.

b. Kinetic therapy devices will have a limit per day (based on 1994 audited cost report data inflated to the rate period). See 12 VAC 30-90-290 for the cost reimbursement limitations.

c. Kinetic therapy devices will be reimbursed only if a resident is being treated for wounds that meet ~~specialized care~~ ~~Complex Health Care Category~~ *the following* wound care criteria. Residents receiving this wound care must require kinetic bed therapy (that is, low air loss mattresses, fluidized beds, and/or rotating/turning beds) and require treatment for a grade (stage) IV decubitus, a large surgical wound that cannot be closed, or second to third degree burns covering more than 10% of the body.

9. Covered ancillary services are defined as follows: laboratory, X-ray, medical supplies (e.g., infusion pumps, incontinence supplies), physical therapy, occupational therapy, speech therapy, inhalation therapy, IV therapy, enteral feedings, and kinetic therapy. The following are not specialized care ancillary services and are excluded from specialized care reimbursement: physician services,

psychologist services, total parenteral nutrition (TPN), and drugs. These services must be separately billed to DMAS. An interim rate for the covered ancillary services will be determined (using data from the most recent settled cost report) by dividing allowable ancillary costs by the number of patient days for the same cost reporting period. The interim rate will be retroactively cost settled based on the specialized care nursing facility cost reporting period.

10. Capital costs. Effective July 1, 2001, capital cost reimbursement shall be in accordance with 12 VAC 30-90-35 through 12 VAC 30-90-37 inclusive, except that the 90% occupancy requirement shall not be separately applied to specialized care. Capital cost related to specialized care patients will be cost settled on the respective nursing facility's cost reporting period. In this cost settlement the 90% occupancy requirement shall be applied to all the nursing facility's licensed nursing facility beds inclusive of specialized care.

To apply this requirement, the following calculation shall be carried out.

a. Licensed beds, including specialized care beds, times days in the cost reporting period shall equal available days.

b. 90% of available days shall equal 90% occupancy days.

c. 90% occupancy days, minus actual resident days including specialized care days shall equal the shortfall of days if it is positive. It shall be set to zero if it is negative.

d. Actual resident days not including specialized care days, plus the shortfall of days shall equal the minimum number of days to be used to calculate the capital cost per day.

11. Nurse aide training and competency evaluation programs and competency evaluation programs (NATCEP) costs. NATCEPS costs will be paid on a pass-through basis in accordance with the current NHPS.

12. Pediatric routine operating cost rate. For pediatric specialized care in a distinct part pediatric specialized care unit, one routine operating cost ceiling will be developed. The routine operating cost ceiling will be computed as follows:

a. The Complex Health Care Payment Rate effective July 1, 1996, and updated for inflation, will be reduced by (i) the weighted average capital cost per day developed from the 1994 audit data and (ii) the weighted average ancillary cost per day from the 1994 audit data updated for inflation in the same manner as described in subdivision 4 a of this subsection.

b. The statewide operating ceiling shall be adjusted for each nursing facility in the same manner as described in subdivisions 4 and 5 of this section.

c. The final routine operating cost reimbursement rate shall be computed as described for other than pediatric units in subdivision 3 of this section.

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13. Pediatric unit capital cost. Pediatric unit capital costs will be reimbursed in accordance with the current NHPS, except that the occupancy requirement shall be 70% rather than 90%.

14. MDS data submission. MDS data relating to specialized care patients must be submitted to the department in a submission separate from that which applies to all nursing facility patients.

a. Within 30 days of the end of each month, each specialized care nursing facility shall submit to the department, separately from its submission of MDS data for all patients, a copy of each MDS Version 2.0 which has been completed in the month for a Medicaid specialized care patient in the nursing facility. This shall include (i) the MDS required within 14 days of admission to the nursing facility (if the patient is admitted as a specialized care patient), (ii) the one required by the department upon admission to specialized care, (iii) the one required within 12 months of the most recent full assessment, and (iv) the one required whenever there is a significant change of status.

b. In addition to the monthly data submission required in subdivision 14 a of this section, the same categories of MDS data required in subdivision 14 a of this section shall be submitted for all patients receiving specialized care from January 1, 1996, through December 31, 1996, and shall be due February 28, 1997.

c. If a provider does not submit a complete MDS record for any patient within the required timeframe, the department shall assume that the RUG-III weight for that patient, for any time period for which a complete record is not provided, is the lowest RUG-III weight in use for specialized care patients. A complete MDS record is one that is complete for purposes of transmission and acceptance by the Health Care Financing Administration.

15. Case mix measures in the initial semiannual periods. In any semiannual periods for which calculations in 12 VAC 39-90-310 requires an NCMI from a semiannual period beginning before January 1996, the case mix used shall be the case mix applicable to the first semiannual period beginning after January 1, 1996, that is a semiannual period in the respective provider's fiscal period. For example, December year-end providers' rates applicable to the month of December 1996, would normally require (in Appendix I (12 VAC 30-90-270 et seq.) of Part III of this chapter) an NCMI from July to December 1995, and one from January to June 1996, to calculate a rate for July to December 1996. However, because this calculation requires an NCMI from a period before January 1996, the NCMI that shall be used will be those applicable to the next semiannual period. The NCMI from January to June 1996, and from July to December 1996, shall be applied to December 1996, as well as to January to June 1997. Similarly, a provider with a March year end would have its rate in December 1996, through March 1997, calculated based on an NCMI from April through September 1996, and October 1996, through March 1997.

16. Cost reports of specialized care providers are due not later than 150 days after the end of the provider's fiscal year. Except for this provision, the requirements of 12 VAC 30-90-70 and 12 VAC 30-90-80 shall apply.

VA.R. Doc. No. R03-250; Filed December 2, 2003, 3:40 p.m.

TITLE 18. PROFESSIONAL AND OCCUPATIONAL LICENSING

BOARD OF DENTISTRY

Title of Regulation: **18 VAC 60-20. Regulations Governing the Practice of Dentistry and Dental Hygiene (amending 18 VAC 60-20-10, 18 VAC 60-20-16, 18 VAC 60-20-20, 18 VAC 60-20-50 through 18 VAC 60-20-90, 18 VAC 60-20-105, 18 VAC 60-20-110, 18 VAC 60-20-120, 18 VAC 60-20-195; adding 18 VAC 60-20-106, 18 VAC 60-20-107, 18 VAC 60-20-135; repealing 18 VAC 60-20-130).**

Statutory Authority: § 54.1-2400 and Chapter 27 (§ 54.1-2700 et seq.) of Title 54.1 of the Code of Virginia.

Public Hearing Date: January 23, 2004 - 9 a.m.

Public comments may be submitted until February 27, 2004.
(See Calendar of Events section for additional information)

Agency Contact: Elaine J. Yeatts, Agency Regulatory Coordinator, Department of Health Professions, 6603 West Broad Street, 5th Floor, Richmond, VA 23230, telephone (804) 662-9918, FAX (804) 662-9114, or e-mail elaine.yeatts@dhp.state.va.us.

Basis: Section 54.1-2400 of the Code of Virginia provides the board the authority to promulgate regulations to administer the regulatory system under its authority to license and regulate dentists and dental hygienists as found in Chapter 27 (§ 54.1-2700 et seq.) of Title 54.1 of the Code of Virginia.

Purpose: As a result of an extensive periodic review of its regulations, the board has proposed amendments to clarify or simplify certain provisions for applicants and licensees and to eliminate unnecessary examinations. Educational criteria, currently applied by the board and required by the Code of Virginia, are spelled out in regulation for a clearer understanding by applicants for licensure. With the intent of protecting the live patients on which the examination is conducted, applicants who fail the clinical examination three times would be required to take additional clinical hours to prepare them for the specific area(s) failed.

The primary intent of amending regulations is to more clearly specify the requirements for administration of sedation or anesthesia. Dentists who administer any form of analgesia, sedation or anesthesia in a dental office must have specific knowledge and training in delivery of those agents and in the monitoring and recovery of a patient. Likewise, it is essential for the dentist to be appropriately prepared and equipped to respond to emergencies that may arise if a patient's breathing

or responses are compromised. Both the dentist and the ancillary personnel should be proficient in handling related complications or emergencies. Therefore, requirements for training, emergency equipment and techniques, and monitoring are necessary to protect the health and safety of patients in dental offices.

Substance: Definitions have been updated to reflect current terminology, particularly that pertaining to revised regulations for anesthesia and sedation and to eliminate terms that were no longer being used. Amendments to the requirements for dental education will reflect the current board interpretation of an accredited or approved dental program, which is either a pre-doctoral dental education program or a one- or two-year post-doctoral dental education program.

Changes in examination requirements offer additional options for persons who took the board-approved examinations five or more years prior to applying for licensure in Virginia. In addition, there are new requirements for remediation for candidates who have failed the licensure examination three times. Rather than requiring passage of a jurisprudence examination, the board will now require that the applicant read and understand the laws and regulations governing the practice of dentistry in Virginia.

Regulations for anesthesia, sedation and analgesia have been rewritten and reorganized to make clear the application of the rules in various settings, the educational and training qualifications of the dentist and dental assistants, the equipment and monitoring needed for each level, and the discharge criteria for ensuring the safety of the patient.

Issues: Advantages and disadvantages to the public: Dentists are increasingly utilizing some form of analgesia, sedation or anesthesia to perform dental procedures with the maximum amount of comfort to their patients. In addition, some oral and maxillofacial surgeons are performing cosmetic surgery in an office-based setting. While the board currently has regulations for anesthesia and sedation, there has been a growing concern that the practitioner qualifications, equipment and monitoring standards were not sufficient to ensure the safety of patients in a dental practice. Most dentists practice with an accepted standard of care, utilizing trained anesthesia providers, equipping their offices with essential rescue and monitoring equipment, and carefully selecting the appropriate anesthesia and informing the patient in advance. These regulations, however, will provide a clearer standard by which dentists are expected to practice and give patients a higher degree of safety when receiving office-based anesthesia. As insurers and practitioners encourage more procedures to be performed in an office-based practice or surgi-center rather than a hospital, these regulations will provide a definite advantage to patients, who typically do not have sufficient knowledge to judge whether the dentist and the facility are appropriately equipped and trained and whether adequate care is being taken to prepare and monitor their recovery. Since the regulations do not apply to the administration of local anesthesia, there should be no effect on the majority of general dentists and no disadvantages to the public in terms of limiting access or increasing cost.

Advantages and disadvantages to the agency: There are no specific advantages or disadvantages to the agency. Regulations that set standards for practice may create an opportunity for complaints for noncompliance, but under current laws and regulations, failure to appropriately provide and monitor anesthesia could be considered substandard care and subject the licensee to disciplinary action. The advantage of these regulations is derived from having more specific, objective standards on which to base such a decision or make findings in a disciplinary case involving sedation or anesthesia. However, with more complete and objective rules to follow, practitioners who are conscientious about their practice and protecting their patients should be able to avoid incidents of unprofessional conduct related to delivery of anesthesia.

Fiscal impact: Projected cost to the state to implement and enforce:

(i) Fund source: As a special fund agency, the board must generate sufficient revenue to cover its expenditures from nongeneral funds, specifically the renewal and application fees it charges to practitioners for necessary functions of regulation.

(ii) Budget activity by program or subprogram: There is no change required in the budget of the Commonwealth as a result of this program.

(iii) One-time versus ongoing expenditures: The agency will incur some one-time costs (less than \$2,000) for mailings to the Public Participation Guidelines mailing lists, conducting a public hearing, and sending copies of final regulations to regulated entities. Every effort will be made to incorporate those into anticipated mailings and board meetings already scheduled.

Projected cost on localities: There are no projected costs to localities.

Description of entities that are likely to be affected by regulation: The entities that are likely to be affected by these regulations would be licensed dentists and dental hygienists.

Estimate of number of entities to be affected: Currently, there are 3,709 dental hygienists and 5,390 dentists who hold a license in Virginia.

Projected costs to the affected entities: For those dentists and ancillary personnel who may not meet the stated qualifications for administration of anesthesia or sedation, there would be some additional cost for compliance. Advanced cardiac life support certification typically requires 16 hours of class at a cost of \$250 to \$300; basic cardiac life support certification requires eight hours of class at a cost of \$150 to \$200. Both courses are available on weekends and do not require any disruption of a work schedule.

Dentists who do not meet the current educational requirements for use of conscious sedation may be able to become qualified under the proposed regulation by completing a 40-hour clinical course. To do so generally necessitates attendance at a seminar or course at a cost of less than \$1,000. Becoming qualified to administer conscious sedation is not necessary to a general dentistry practice; it would be a choice based on a

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practitioner's decision that it would be beneficial to his practice and his patients to have that option available. Therefore, any cost incurred for completion of the required hours of training would be more than offset by additional fees that could be charged for that service.

Department of Planning and Budget's Economic Impact Analysis: The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with § 2.2-4007 H of the Administrative Process Act and Executive Order Number 21 (02). Section 2.2-4007 H requires that such economic impact analyses include, but need not be limited to, the projected number of businesses or other entities to whom the regulation would apply, the identity of any localities and types of businesses or other entities particularly affected, the projected number of persons and employment positions to be affected, the projected costs to affected businesses or entities to implement or comply with the regulation, and the impact on the use and value of private property. The analysis presented below represents DPB's best estimate of these economic impacts.

Summary of the proposed regulation. The Board of Dentistry (board) proposes to: (i) allow applicants who successfully complete the board-approved examinations five or more years prior to the date of receipt of their applications to avoid retaking the exam if they complete board-approved continuing education, (ii) allow applicants who successfully complete the board-approved examinations five or more years prior to the date of receipt of their applications to avoid retaking the exam if they have maintained continuous practice in 48 out of the past 60 months, (iii) allow dental hygienists to provide a mailing address with a post office box number rather than a street address, (iv) add two sponsors to the list from which the board will approve continuing education credit, (v) require that dental hygienists applying for licensure by endorsement submit a current report from the Healthcare Integrity and Protection Data Bank, (vi) require candidates for dentistry licensure who have failed any section of the board-approved examination three times to complete a minimum of 14 hours of additional clinical training in each section of the examination to be retested, in order to be approved by the board to sit for the examination a fourth time, (vii) require candidates for dental hygienist licensure who have failed any section of the board-approved examination three times to complete a minimum of 7 hours of additional clinical training in each section of the examination to be retested, in order to be approved by the board to sit for the examination a fourth time, (viii) eliminate the examination on knowledge of Virginia's laws and regulations, (ix) require dentists who administer general anesthesia or conscious sedation to hold current certification in Advanced Cardiac Life Support or Pediatric Advanced Life Support, (x) require that ancillary personnel who assist in the administration and monitoring of conscious or deep sedation have Basic Cardiac Life Support (CPR) certification or hold certification as a certified anesthesia assistant, (xi) add one method and rescind another method for receiving radiation certification, and (xii) make several clarifications.

Estimated economic impact. Exemptions from retaking the licensure examination. Unlike dental hygienists, dentists cannot obtain licensure by endorsement under these regulations. On the other hand, the dental examinations

required by the board are those administered by the Southern Regional Testing Agency (SRTA).¹ In addition to Virginia, Arkansas, Georgia, Kentucky, South Carolina, and Tennessee are members of SRTA.² Dentists from these states will likely have passed the SRTA exams in order to have become licensed in their home state. If they passed the SRTA exams within the last five years, they will not need to retake the exams to obtain licensure in Virginia. The current regulations also permit applicants who successfully complete the board-approved examinations five or more years prior to the date of the board's receipt of their applications for licensure to waive retaking the board-approved examinations (SRTA) if they demonstrate that they have maintained continuous clinical, ethical, and legal practice since passing the approved exam. Thus, licensed dentists from Arkansas, Georgia, Kentucky, South Carolina, and Tennessee who obtained licensure by passing the SRTA exams and have maintained continuous clinical, ethical, and legal practice since can obtain a license in Virginia without having to take more examinations.

The board proposes to allow applicants who passed the board-approved (SRTA) examinations five or more years ago to waive retaking the exams if they have maintained clinical, ethical, and legal practice for 48 of the past 60 months, instead of the current continuous practice requirement. The board also proposes to permit applicants who passed the board-approved (SRTA) examinations five or more years ago and have not been in practice for at least 48 of the past 60 months to take board-approved continuing education in lieu of retaking the exams. The proposed regulations do not specify how much continuing education is required. According to the Department of Health Professions (department), the board will decide the amount of continuing education that it will require on a case-by-case basis. By relaxing the continuous practice requirement and by allowing continuing education credits to serve in lieu of retaking the SRTA examinations, more dentists currently licensed in Arkansas, Georgia, Kentucky, South Carolina, and Tennessee may seek to become licensed in Virginia and provide dental services in the Commonwealth. To the extent that the proposed changes effectively increase the number of dentists from these states that obtain Virginia licensure and begin practicing in the Commonwealth, the supply of dental services in Virginia will increase. Increasing the supply of a good or service will tend to reduce its market price. If the cost of dental services is reduced, more people will be able to afford dental care, consequently receiving the benefit of improved health.

Typically, no demonstration of knowledge is required to obtain continuing education credits. Only attendance is mandated. Thus, accepting continuing education credits in lieu of retaking exams is effectively eliminating a requirement to demonstrate knowledge. On the other hand, accepting continuing education credits in lieu of retaking exams for dentists who are applying for licensure in Virginia and are licensed in Arkansas, Georgia, Kentucky, South Carolina, and Tennessee, but have practiced actively for less than four of the previous five years, treats these dentists more in line with Virginia dentists with

¹ Source: the Southern Regional Testing Agency Website, www.srta.org

² Ibid

inactive licensure status. Dentists with an inactive Virginia license must complete up to 45 hours of continuing education in order to reactivate their licenses and resume practice.

Dentists from all other states (non-SRTA states), including the neighboring states of Maryland and North Carolina, must take and pass examinations in order to obtain licensure in Virginia, regardless of their accomplishments and the content of the licensure-qualifying examinations they have passed in their home states. This discourages the potential entry of highly skilled dentists into Virginia. For example, excellent dentists based in the Maryland suburbs of Washington, D.C. may consider opening offices in Northern Virginia, but are discouraged from doing so due to the time and costs associated with taking additional licensure examinations in order to obtain Virginia licensure. Or for another example, say an outstanding dentist who has passed very rigorous licensure examinations in her home non-SRTA state is contemplating a move to the Commonwealth and practicing here because her spouse has received an interesting employment offer in Virginia. The time and costs required for preparation, as well as perhaps annoyance at being required to take unnecessary examinations, may discourage this highly qualified dentist from seeking licensure and providing dental services in Virginia.

Besides SRTA, there are three other regional examining boards: (i) the North East Regional Board (NERB), with member states Connecticut, Illinois, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New Jersey, New York, Ohio, Pennsylvania, Rhode Island, Vermont, West Virginia, and the District of Columbia, (ii) the Central Regional Dental Testing Service (CRDTS), with member states Colorado, Illinois, Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, South Dakota, Wisconsin, and Wyoming; and (iii) the Western Regional Examining Board (WREB), with member states Alaska, Arizona, Idaho, Montana, New Mexico, Oklahoma, Oregon, Texas, Utah, and Washington. The remaining ten states, Alabama, California, Delaware, Hawaii, Florida, Indiana, Louisiana, Mississippi, Nevada, and North Carolina do not belong to a regional board. Unless the NERB, CRDTS, and WREB exams, and the licensing exams for the unaligned states, are significantly less stringent than the SRTA exams, there is no justification for mandating that licensed dentists from these states who have passed their state's licensing exams take and pass the SRTA exams for Virginia licensure. By discouraging non-SRTA state dentists from seeking licensure in Virginia, the quantity and perhaps quality of dental services in Virginia are lower than they otherwise would be, while the costs of dental services are higher.

Discouraging highly skilled dentists from practicing in Virginia clearly reduces the supply of dental services in Virginia. If there are fewer suppliers of a good or service and the demand for the good or service has not changed, then it can be expected that the market price will increase. Thus, by discouraging highly skilled dentists who have passed licensure examinations in other states that are at least as rigorous as Virginia's from providing dental services in the Commonwealth, the prices paid for dental services in Virginia are likely higher than they would otherwise be. If the cost of dental services is increased, fewer people are able to afford

dental care; consequently fewer people will receive the health benefits of dental care.

The overall average quality of dental services may be reduced as well. This is the case for two reasons. First, discouraging dentists who have passed licensure examinations that are more rigorous than Virginia's from seeking licensure in the Commonwealth results in fewer dentists providing services in Virginia who have met and passed a higher standard indicating knowledge and skills than is required here. Second, when there is greater competition in the supply of a good or service, suppliers are under greater pressure to produce high quality in order to keep and obtain customers.

Dental hygienists' mailing address. Currently, dental hygienists are required to provide the board with their current resident address. The regulations specifically state, "No post office box numbers are accepted." Licensee information is posted on the department's website. Since no post office box numbers are accepted, the current requirement effectively requires dental hygienists to have their home address, including the street name and number, published on the Internet. Some dental hygienists have expressed serious privacy and safety concerns about having their home address readily available on the Internet. Such available information may increase the likelihood of harassment at home, for example. The board proposes to instead require that dental hygienists provide the board with their current mailing address. The "No post office box numbers are accepted" language is deleted. This proposal creates a net benefit since the hygienists' privacy and safety concerns are alleviated by the removal of the home street address requirement, and the board and department find the proposed required information to be adequate.

Continuing education sponsors. Licensed dentists and dental hygienists are required to complete 15 hours of approved continuing education. These regulations contain a list of approved sponsors of continuing education. The board proposes to add "The MCV Orthodontic and Research Foundation" and "The Dental Assisting National Board" to the list of sponsors from which the board will approve continuing education credit. Though the regulations have and will continue to have "Any other board approved programs" on the list of approved sponsors of continuing education, adding these sponsors by name will have some impact. Specific programs have to be approved by the board, and listing these two organizations as approved enable licensees to know that courses that they offer are acceptable. This saves on the time and resources necessary for licensees to inquire about whether the board will accept continuing education credit from these organizations, as well as the time and resources necessary for the department to respond. Since these costs will not have to be expended to determine if courses from these organizations are acceptable under the proposed regulations, these two organizations will likely obtain more participants in their continuing education programs.

Licensure by endorsement for dental hygienists. A dental hygienist can obtain a Virginia licensure by endorsement if he is licensed in good standing in another state which has a clinical licensing examination substantially equivalent to that required by Virginia, and has had "clinical, ethical and legal

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practice for 24 out of the past 48 months immediately preceding application for licensure" in Virginia. The board proposes to require that applicants for licensure by endorsement submit a current report from the Healthcare Integrity and Protection Data Bank (HIDB). The HIDB report lists disciplinary actions in other states. The cost for the applicant is \$8.50.³ By obtaining the report the board will be better able to be kept aware of possible past poor practice by applicants for licensure by endorsement. The improved information on the applicant's work history will allow the board to better evaluate whether applicants are likely to put the public at risk due to unethical or grossly incompetent service. Since the cost for the applicant is relatively small, and the benefit to the Commonwealth is potentially large, this proposed amendment will likely produce a net benefit.

Remedial training. Under the current regulations, a candidate who repeatedly fails sections of the dental or dental hygienist licensure exams may continue to retake those sections until he passes. In regard to the dental licensure exam, the board proposes that "If the candidate has failed any section of the board-approved examination three times, he shall complete a minimum of 14 hours of additional clinical training in each section of the examination to be retested, in order to be approved by the board to sit for the examination a fourth time." The proposed minimum amount of remedial clinical training for candidates who have failed a section of the dental hygienist exam three times is seven hours. In dental and dental hygienist exams, candidates perform procedures on actual patients. The patients are typically individuals that have volunteered to receive dental work by students in exchange for reduced fees or no payment.⁴

Allowing examinees to repeatedly perform failing-quality dental work on live patients clearly has a negative impact on those patients. Requiring additional clinical training for candidates who repeatedly fail will likely reduce the amount of poor dental work performed on the patients receiving reduced fee dental services during examinations. This is the case for two reasons: (i) additional hours of training may result in improved performance, and (ii) the additional time and cost may discourage some repeated exam-failing candidates from retaking the exam. The likely reduction in failing-quality dental and dental hygienist work is particularly beneficial for Virginians of lesser means, since people with fewer resources are more likely to choose dental services from dental students in exchange for reduced fees or no payment.

Additional clinical training costs about \$100 per hour for both dentists and dental hygienists.⁵ Thus candidates who choose to pursue a fourth try at a previously failed section will pay about \$1,400 in fees for the proposed required additional 14 hours of clinical training. The \$1,400 figure does not include the value of the candidates' time and travel costs associated with obtaining and taking the additional clinical training. According to the department, it is very unusual for candidates to fail the same section three times. Thus, this proposal will be applicable on only rare occasions.

Jurisprudence examination. All applicants for licensure must currently pass an examination on the content of the applicable Virginia dental or dental hygiene laws and regulations in order to obtain licensure. The board proposes to no longer require that applicants take such an exam. Instead, applicants must "attest that they have read and understand" the applicable Virginia dental or dental hygiene laws and regulations. Eliminating the jurisprudence exam requirement saves applicants the exam fee as well as the time of taking the exam and traveling to and from the test center. The test fee is \$55 and it takes approximately one hour to complete the exam.⁶ According to the department, testing centers exist throughout the Commonwealth. In addition, applicants will likely spend less time reading the rules and regulations prior to attesting to their understanding, than they currently spend studying for the jurisprudence exam.

Eliminating the jurisprudence exam requirement will also likely result in some dentists and dental hygienists not understanding Virginia's laws and regulations as well as they would with the requirement. Attesting to understanding documents does not provide the same assurance of knowledge as passing a test on its contents. The impact of some dentists and dental hygienists not understanding Virginia's laws and regulations as well as they would otherwise is unknown. The impact depends on how many dentists and dental hygienists are less well informed once the change takes effect, what topics they are less well informed about, whether being less well-informed affects their actions, and how their actions change if they change. None of these factors are known.

Advanced Cardiac Life Support and Basic Cardiac Life Support. The board proposes to require that dentists who administer either deep sedation/general anesthesia or conscious sedation hold current certification in Advanced Cardiac Life Support (ACLS) or Pediatric Advanced Life Support (PALS) from the American Heart Association. This proposal is based upon the recommendation of a panel assembled by the board that consisted of dental school faculty and practicing oral and maxillofacial surgeons. It was the judgment of the panel that dentists who have not demonstrated the knowledge necessary to obtain certification potentially put their patients' health at risk. This certification is already required for physicians who administer sedation. All or nearly all oral and maxillofacial surgeons in Virginia hold certification in ACLS or PALS.⁷ This is due to the surgeons' belief in its necessity, as well as its requirement by malpractice insurance companies.⁸ Thus, this proposal will most likely not affect oral and maxillofacial surgeons. The panel believes that some general dentistry practitioners who administer conscious sedation may not be certified in ACLS or PALS. The panel does not have a research estimate of the safety risk posed by dentists administering conscious sedation without ACLS or PALS certification, but believes that it is significant.

³ Source: Department of Health Professions

⁴ Ibid

⁵ Ibid

⁶ Ibid

⁷ Source: Board of Dentistry's anesthesia panel

⁸ Ibid

ACLS certification typically requires 16 hours of class with fees from \$250 to \$300.⁹ PALS certification requires additional time and fees.¹⁰ In addition to fees, dentists' time also has value. The mean hourly wage for dentists in Virginia is \$57.73.¹¹ Assuming that the value of a dentist's time is equal to his mean hourly wage, and not accounting for travel expenses, it would cost a dentist \$923.68¹² on average to comply with the proposed certification requirement. Since estimates of dentists' improved ability to handle adverse reactions to conscious sedation due to ACLS or PALS certification are unavailable, an accurate comparison of the benefit of requiring ACLS or PALS certification to its cost cannot be made.

The board also proposes to require that ancillary personnel who assist in the administration and monitoring of conscious or deep sedation have Basic Cardiac Life Support (CPR) certification or hold certification as a certified anesthesia assistant (CAA). Having more than one person present who can perform CPR may help improve survival chances for someone in cardiac arrest. Additionally, if the dentist administering anesthesia becomes incapacitated, it can be beneficial to have another individual present who can help in resuscitation. The panel believes that it is common, but not universal, for ancillary personnel to have at least CPR training.

CPR certification typically requires 8 hours of class at a cost of \$150 to \$200.¹³ CAA requires more time and higher fees.¹⁴ The mean hourly wage for dental assistants in Virginia is \$12.95¹⁵ Assuming that the value of a dental assistant's time is equal to his mean hourly wage, and not accounting for travel expenses, it would cost a dental assistant \$207.20¹⁶ on average to comply with the proposed certification requirement. Since estimates of improved health outcomes due to the ancillary personnel who assist in the administration and monitoring of conscious or deep sedation having had training in CPR are not available, an accurate comparison of the benefit of requiring this certification to its cost cannot be made.

Radiation certification. Under the current regulations there are four methods by which an individual may become certified to place or expose dental X-ray film: 1) satisfactorily complete a course or examination recognized by the Commission on Dental Accreditation of the American Dental Association, 2) be certified by the American Registry of Radiologic Technologists, 3) satisfactorily complete a course and pass an examination in compliance with guidelines provided by the board, or 4) pass the board's examination in radiation safety and hygiene followed by on-the-job training. According to the department, the board's exam is very rarely requested. In order to save on the costs of maintaining the rarely used exam, the board proposes to discontinue it and eliminate the

current fourth option for obtaining radiation certification. The board proposes to introduce a new fourth option, satisfactory completion of a radiation course and passage of an exam given by the Dental Assisting National Board. Since the board exam is very rarely used and it is costly to maintain, discontinuing the option to gain radiation certification via a board exam will likely produce a net benefit. Adding the Dental Assisting National Board as an approved source from which to obtain radiation certification can be beneficial to the extent that individuals will find it an attractive option.

Businesses and entities affected. The proposed amendments affect the 5,390 licensed dentists, 3,709 licensed dental hygienists, their patients and practices, dental schools, dental hygienist schools, and their students and faculty.

Localities particularly affected. The proposed regulations affect all Virginia localities.

Projected impact on employment. By relaxing the continuous practice requirement and by allowing continuing education credits to serve in lieu of retaking the SRTA examinations, more dentists currently licensed in Arkansas, Georgia, Kentucky, South Carolina, and Tennessee may seek to become licensed and open practices or join current practices in Virginia. The total number of new individuals who open or join dental practices in the Commonwealth due to this change is likely to be small. The addition of a small number of new dentists practicing in Virginia would likely prompt the hiring of a small number of new support personnel, such as dental hygienists and dental assistants.

Effects on the use and value of private property. A small number of new dental practices may be established or expanded due to the proposed relaxation of the continuous practice requirement and the permitting of continuing education credits to serve in lieu of retaking the SRTA examinations.

The value of the MCV Orthodontic and Research Foundation and the Dental Assisting National Board may increase somewhat due to increased demand for their continuing education courses stemming from the proposal to list those organizations as approved continuing education sponsors. The value of the Dental Assisting National Board may also increase if their listing as an approved source from which to obtain radiation certification produces new demand for their services.

The proposals to require dentists who administer either deep sedation/general anesthesia or conscious sedation hold current certification in Advanced Cardiac Life Support (ACLS) or Pediatric Advanced Life Support (PALS) from the American Heart Association and to require that ancillary personnel who assist in the administration and monitoring of conscious or deep sedation have Basic Cardiac Life Support (CPR) certification or hold certification as a certified anesthesia assistant (CAA) will provide additional demand for these services from the organizations that provide them. The value of these organizations will consequently increase.

Agency's Response to the Department of Planning and Budget's Economic Impact Analysis: The Board of Dentistry does not concur with the analysis of the Department of

⁹ Source: Department of Health Professions

¹⁰ Ibid

¹¹ Source: U.S. Department of Labor, Bureau of Labor Statistics, 2001 State Occupational Employment and Wage Estimates

¹² 16 x \$57.73 = \$923.68

¹³ Source: Department of Health Professions

¹⁴ Ibid

¹⁵ Source: U.S. Department of Labor, Bureau of Labor Statistics, 2001 State Occupational Employment and Wage Estimates

¹⁶ 16 x \$12.95 = \$207.20

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Planning and Budget (DPB) for amendments to 18 VAC 60-20 pursuant to a periodic review of regulations. The board is concerned that the analysis fails to consider provisions in the Code of Virginia and that it inaccurately represents the supply and demand economics associated with the practice of dentistry.

The economic impact analysis notes that "dentists cannot obtain licensure by endorsement under these regulations." DPB has raised an issue in current regulation that was not the subject of this regulatory action and which the board could not address in its periodic review. The regulatory action on which the department is required to prepare an analysis did not involve the issue of licensure by endorsement, nor was there any identification of the issue of endorsement for dentists raised in the Notice of Intended Regulatory Action. Therefore, it would have been inappropriate for the board to address it in the proposed amendments.

In addition, the department is incorrect in stating that licensure by endorsement is not permitted because regulations of the board do not allow it. Regulations must be based on statute, and there is a statutory provision that is interpreted as prohibiting licensure by endorsement, so any modification of that policy would require action by the General Assembly. Prior to 1995, regulations of the Board of Dentistry did provide for licensure by endorsement. In the 1995 Session of the General Assembly, SB 767 was passed to "prohibit licensure by endorsement for the practice of dentistry in the Commonwealth" (Summary of bill by Legislative Services). The bill provided that "notwithstanding the provisions of § 54.1-103 C, it shall be unlawful for any person to practice dentistry or to receive a licensure from any commissioner of the revenue to practice dentistry, unless he has passed the examination and obtained a license." The examination accepted for licensure in Virginia is the examination of the Southern Regional Testing Agency (SRTA).

Other comments by DPB in its analysis related to licensure by endorsement do not seem to be factually supported. DPB asserts that discouraging non-SRTA state dentists from seeking licensure in Virginia lowers the quantity and quality of dental services, while the costs of such services are higher. No data has been provided to support the contention that the quality of dental care is lower and the costs higher than in other states. Costs are more related to the general cost of living in an area than to the availability of dentists. For example, costs for dental services are higher in Northern Virginia than they are in Southside Virginia, although the number of dentists in more urban areas is higher for the population they serve.

In its EIA, DPB also asserts that the licensure examinations in other regions are more rigorous than Virginia's, resulting in the overall average quality of dental services being reduced. The analysis claims that dentists in non-SRTA states have "met and passed a higher standard indicating knowledge and skills than is required here." Yet, DPB has not provided any data or study to support such an assertion, and the board takes exception to a prejudicial statement about the licensure examination and about the quality of dental services in Virginia.

Finally, there is a statement asserting that "no demonstration of knowledge is required to obtain continuing education credits...only attendance is mandated." While attendance may be the only criteria for obtaining CE credits by some providers, some courses have a clinical component and others have passage of a post-test required for credit. So it is not entirely accurate to state that there is no demonstration of knowledge in the acquisition of continuing education.

Summary:

The proposed amendments update definitions to reflect current terminology, particularly that pertaining to revised regulations for anesthesia and sedation and eliminate terms that are no longer being used. Amendments to the requirements for dental education will reflect the current board interpretation of an accredited or approved dental program, which is either a pre-doctoral dental education program or a one- or two-year post-doctoral dental education program.

Changes in examination requirements offer additional options for persons who took the board-approved examinations five or more years prior to applying for licensure in Virginia. In addition, there are new requirements for remediation for candidates who have failed the licensure examination three times. Rather than requiring passage of a jurisprudence examination, the board will now require that the applicant read and understand the laws and regulations governing the practice of dentistry in Virginia.

Regulations for anesthesia, sedation and analgesia have been rewritten and reorganized to make clear the application of the rules in various settings, the educational and training qualifications of the dentist and dental assistants, the equipment and monitoring needed for each level, and the discharge criteria for ensuring the safety of the patient.

18 VAC 60-20-10. Definitions.

The following words and terms when used in this chapter shall have the following meanings unless the context clearly indicates otherwise:

"ADA" means the American Dental Association.

"Advertising" means a representation or other notice given to the public or members thereof, directly or indirectly, by a dentist on behalf of himself, his facility, his partner or associate, or any dentist affiliated with the dentist or his facility by any means or method for the purpose of inducing purchase, sale or use of dental methods, services, treatments, operations, procedures or products, or to promote continued or increased use of such dental methods, treatments, operations, procedures or products.

"Analgesia" means the diminution or elimination of pain in the conscious patient.

"Anxiolysis" means the diminution or elimination of anxiety through the use of pharmacological agents in a dosage that does not cause depression of consciousness.

"Approved schools" means those dental schools, colleges, departments of universities or colleges, or schools of dental hygiene programs currently accredited by the Commission on Dental Accreditation of the American Dental Association.

"Competent instructor" means any person appointed to the faculty of a dental school, college or department or a university or a college who holds a license or teacher's license to practice dentistry or dental hygiene in the Commonwealth.

"Conscious sedation" means a minimally depressed level of consciousness that retains the patient's ability to independently and continuously maintain an airway and respond appropriately to physical stimulation and verbal commands, produced by a pharmacologic or nonpharmacologic method *pharmacological or nonpharmacological methods, including inhalation, parenteral, transdermal or enteral*, or a combination thereof.

"Deep sedation/general anesthesia" means an induced state of depressed consciousness or unconsciousness accompanied by a complete or partial loss of protective reflexes, including the inability to continually maintain an airway independently and/or respond purposefully to physical stimulation or verbal command and is produced by a pharmacologic or nonpharmacological method or a combination thereof.

"Dental assistant" means any unlicensed person under the supervision of a dentist who renders assistance for services provided to the patient as authorized under this chapter but shall not include an individual serving in purely a secretarial or clerical capacity.

"Direction" means the presence of the dentist for the evaluation, observation, advice, and control over the performance of dental services.

"Enteral" is any technique of administration in which the agent is absorbed through the gastrointestinal tract or oral mucosa (i.e., oral, rectal, sublingual).

~~"General anesthesia" means a controlled state of unconsciousness accompanied by partial or complete loss of protective reflexes, including inability to independently maintain an airway and respond purposefully to physical stimulation or verbal command, produced by a pharmacologic or nonpharmacologic method, or combination thereof.~~

"General supervision" means that the dentist has evaluated the patient and issued a written order for the specific, authorized services to be provided by a dental hygienist when the dentist is not present in the facility while the services are being provided.

"Inhalation" is a technique of administration in which a gaseous or volatile agent, including nitrous oxide, is introduced into the pulmonary tree and whose primary effect is due to absorption through the pulmonary bed.

"Inhalation analgesia" means the inhalation of nitrous oxide and oxygen to produce a state of reduced sensibility to pain without the loss of consciousness.

"Local anesthesia" means the loss of sensation or pain in the oral cavity or ~~its contiguous~~ *the maxillofacial or adjacent and associated* structures generally produced by a topically applied

agent or injected agent without causing the loss *depressing the level* of consciousness.

~~"Monitoring general anesthesia and conscious sedation" includes the following: recording and reporting of blood pressure, pulse, respiration, and other vital signs to the attending dentist during the conduct of these procedures and after the dentist has induced a patient and established a maintenance level.~~

~~"Monitoring nitrous oxide oxygen inhalation analgesia" means making the proper adjustments of nitrous oxide machines at the request of the dentist during the administration of the sedation, and observing the patient's vital signs.~~

~~"Nitrous oxide oxygen inhalation analgesia" means the utilization of nitrous oxide and oxygen to produce a state of reduced sensibility to pain designating particularly the relief of pain without the loss of consciousness.~~

"Parenteral" means a technique of administration in which the agent is injected into tissues, either subcutaneous, sublingual, submucosal, intramuscular or intravenous.

"Radiographs" means intraoral and extraoral x-rays of the hard and soft ~~oral structures~~ *tissues* to be used for purposes of diagnosis.

18 VAC 60-20-16. Address of record.

At all times, each licensed dentist shall provide the board with a current, primary business address, and each dental hygienist shall provide a current ~~resident~~ *mailing* address. ~~No post office box numbers are accepted.~~ All required notices mailed by the board to any such licensee shall be validly given when mailed to the latest address given by the licensee. All changes of address shall be furnished to the board in writing within 30 days of such changes.

18 VAC 60-20-20. License renewal and reinstatement.

A. Renewal fees. Every person holding an active or inactive license, a full-time faculty license, or a restricted volunteer license to practice dentistry or dental hygiene shall, on or before March 31, renew his license. Every person holding a teacher's license or a temporary permit to practice dentistry or dental hygiene shall, on or before June 30, renew his license.

1. The fee for renewal of an active license or permit to practice or teach dentistry shall be \$150, and the fee for renewal of an active license or permit to practice or teach dental hygiene shall be \$50.

2. The fee for renewal of an inactive license shall be \$75 for dentists and \$25 for dental hygienists.

3. The fee for renewal of a restricted volunteer license shall be \$15.

B. Late fees. Any person who does not return the completed form and fee by the deadline required in subsection A of this section shall be required to pay an additional late fee of \$50 for dentists and \$20 for dental hygienists. The board shall renew a license if the renewal form, renewal fee, and late fee are received within one year of the deadline required in subsection A of this section.

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C. Reinstatement fees and procedures. The license of any person who does not return the completed renewal form and fees by the deadline required in subsection A of this section shall automatically expire and become invalid and his practice of dentistry/dental hygiene shall be illegal.

1. Any person whose license has expired for more than one year and who wishes to reinstate such license shall submit to the board a reinstatement application, the renewal fee and the reinstatement fee of \$225 for dentists and \$135 for dental hygienists.

2. Practicing in Virginia with an expired license may subject the licensee to disciplinary action and additional fines by the board.

3. The executive director may reinstate such expired license provided that the applicant can demonstrate continuing competence, that no grounds exist pursuant to § 54.1-2706 of the Code of Virginia and 18 VAC 60-20-170 to deny said reinstatement, and that the applicant has paid the unpaid renewal fee, the reinstatement fee and any fines or assessments. *Evidence of continuing competence shall include hours of continuing education and may also include evidence of active practice in another state or current specialty board certification.*

D. Reinstatement of a license previously revoked or indefinitely suspended. Any person whose license has been revoked shall submit to the board for its approval a reinstatement application and fee of \$750 for dentists and \$500 for dental hygienists. Any person whose license has been indefinitely suspended shall submit to the board for its approval a reinstatement application and fee of \$350 for dentists and \$250 for dental hygienists.

18 VAC 60-20-50. Requirements for continuing education.

A. After April 1, 1995, a dentist or a dental hygienist shall be required to have completed a minimum of 15 hours of approved continuing education for each annual renewal of licensure. Continuing education hours for dentists in excess of the number required for renewal may be transferred or credited to ~~another~~ *the next renewal* year for a total of not more than 15 hours.

B. An approved continuing dental education program shall be relevant to the treatment and care of patients and shall be:

1. Clinical courses in dentistry and dental hygiene; or
2. Nonclinical subjects that relate to the skills necessary to provide dental or dental hygiene services and are supportive of clinical services (i.e., patient management, legal and ethical responsibilities, stress management). Courses not acceptable for the purpose of this subsection include, but are not limited to, estate planning, financial planning, investments, and personal health.

C. Continuing education credit may be earned for verifiable attendance at or participation in any courses, to include audio and video presentations, which meet the requirements in subdivision B 1 of this section and which are given by one of the following sponsors:

1. American Dental Association and National Dental Association, their constituent and component/branch associations;

2. American Dental Hygienists' Association and National Dental Hygienists Association, their constituent and component/branch associations;

3. American Dental Assisting Association, its constituent and component/branch associations;

4. American Dental Association specialty organizations, their constituent and component/branch associations;

5. American Medical Association and National Medical Association, their specialty organizations, constituent, and component/branch associations;

6. Academy of General Dentistry, its constituent and component/branch associations;

7. Community colleges with an accredited dental hygiene program if offered under the auspices of the dental hygienist program;

8. A college, university, or hospital service which is accredited by an accrediting agency approved by the U.S. Office of Education;

9. The American Heart Association, the American Red Cross and the American Cancer Society;

10. A medical school which is accredited by the American Medical Association's Liaison Committee for Medical Education;

11. State or federal government agencies (i.e., military dental division, Veteran's Administration, etc.);

12. The Commonwealth Dental Hygienists' Society; or

13. *The MCV Orthodontic and Research Foundation;*

14. *The Dental Assisting National Board; or*

~~15.~~ 15. Any other board-approved programs.

D. A licensee is exempt from completing continuing education requirements and considered in compliance on the first renewal date following his initial licensure.

E. The board may grant an exemption for all or part of the continuing education requirements due to circumstances beyond the control of the licensee, such as temporary disability, mandatory military service, or officially declared disasters.

F. A licensee is required to provide information on compliance with continuing education requirements in his annual license renewal. Following the renewal period, the board may conduct an audit of licensees to verify compliance. Licensees selected for audit must provide original documents certifying that they have fulfilled their continuing education requirements by the deadline date as specified by the board.

G. All licensees are required to maintain original documents verifying the date and subject of the program or activity. Documentation must be maintained for a period of four years following renewal.

H. A licensee who has allowed his license to lapse, or who has had his license suspended or revoked, must submit evidence of completion of continuing education equal to the requirements for the number of years in which his license has not been active, *not to exceed a total of 45 hours*.

I. Continuing education hours required by disciplinary order shall not be used to satisfy the continuing education requirement for license renewal.

J. Failure to comply with continuing education requirements may subject the licensee to disciplinary action by the board.

18 VAC 60-20-60. Education.

A. Dental licensure. An applicant for dental licensure shall be a graduate and a holder of a diploma *or a certificate* from an accredited ~~or approved~~ dental ~~school~~ program recognized by the Commission on Dental Accreditation of the American Dental Association, *which consists of either a pre-doctoral dental education program or at least a 12-month post-doctoral advanced general dentistry program or a post-doctoral dental education program in any other specialty*.

B. Dental hygiene licensure. An applicant for dental hygiene licensure shall have graduated from or have been issued a certificate by an accredited school or program of dental hygiene recognized by the Commission on Dental Accreditation of the American Dental Association.

18 VAC 60-20-70. Licensure examinations.

A. Dental examinations.

1. All applicants shall have successfully completed Part I and Part II of the examinations of the Joint Commission on National Dental Examinations prior to making application to this board.

2. All applicants to practice dentistry shall satisfactorily pass the complete board-approved examinations in dentistry. Applicants who successfully completed the board-approved examinations five or more years prior to the date of receipt of their applications for licensure by this board may be required to retake the examinations *or take board-approved continuing education* unless they demonstrate that they have maintained ~~continuous~~ clinical, ethical and legal practice ~~since passing the board-approved examinations for 48 of the past 60 months immediately prior to submission of an application for licensure~~.

3. *If the candidate has failed any section of the board-approved examination three times, he shall complete a minimum of 14 hours of additional clinical training in each section of the examination to be retested in order to be approved by the board to sit for the examination a fourth time.*

B. Dental hygiene examinations.

1. All applicants are required to successfully complete the dental hygiene examination of the Joint Commission on National Dental Examinations prior to making application to this board for licensure.

2. All applicants to practice dental hygiene shall successfully complete the board-approved examinations in

dental hygiene, except those persons eligible for licensure pursuant to 18 VAC 60-20-80.

3. *If the candidate has failed any section of the board-approved examination three times, he shall complete a minimum of seven hours of additional clinical training in each section of the examination to be retested in order to be approved by the board to sit for the examination a fourth time.*

C. Applicants who successfully complete the board-approved examinations five or more years prior to the date of receipt of their applications for licensure by this board may be required to retake the board-approved examinations *or take board-approved continuing education* unless they demonstrate that they have maintained ~~continuous~~ clinical, ethical, and legal practice ~~since passing the board-approved examinations for 48 of the past 60 months immediately prior to submission of an application for licensure~~.

D. All applicants for licensure by examination shall be required to ~~pass an examination on~~ *attest that they have read and understand* the applicable Virginia dental and dental hygiene laws and the regulations of this board.

18 VAC 60-20-80. Licensure by endorsement for dental hygienists.

An applicant for dental hygiene endorsement licensure shall:

1. Be a graduate or be issued a certificate from an accredited dental hygiene school/program of dental hygiene recognized by the Commission on Dental Accreditation of the American Dental Association;

2. Be currently licensed to practice dental hygiene in another state, territory, District of Columbia, or possession of the United States, and have ~~continuous~~ clinical, ethical, and legal practice for 24 out of the past 48 months immediately preceding application for licensure. ~~Active patient care in armed forces dental corps, state or federal agency, volunteer practice in a public clinic, and intern or residency programs, may substitute for required clinical practice;~~

3. Be certified to be in good standing from each state in which he is currently licensed or has ever held a license;

4. Have successfully completed a clinical licensing examination substantially equivalent to that required by Virginia;

5. Not have failed the clinical examination accepted by the board within the last five years;

6. Be of good moral character;

7. Not have committed any act which would constitute a violation of § 54.1-2706 of the Code of Virginia;

8. Have successfully completed the dental hygiene examination of the Joint Commission on National Dental Examinations prior to making application to this board; ~~and~~

9. ~~Pass an examination on~~ *Attest to having read and understand* the laws and the regulations governing the practice of dentistry and dental hygiene in Virginia; *and*

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10. Submit a current report from the Healthcare Integrity and Protection Data Bank (HIPDB).

18 VAC 60-20-90. Temporary permit, teacher's license, and full-time faculty license.

A. A temporary permit shall be issued only for the purpose of allowing dental and dental hygiene practice as limited by §§ 54.1-2715 and 54.1-2726 of the Code of Virginia.

B. A temporary permit will not be renewed unless the permittee shows that extraordinary circumstances prevented the permittee from taking the licensure examination during the term of the temporary permit.

C. A full-time faculty license shall be issued to any dentist who meets the entry requirements of § 54.1-2713 of the Code of Virginia, who is certified by the dean of a dental school in the Commonwealth and who is serving full time on the faculty of a dental school or its affiliated clinics intramurally in the Commonwealth.

1. A full-time faculty license shall remain valid only while the license holder is serving full time on the faculty of a dental school in the Commonwealth. When any such license holder ceases to continue serving full time on the faculty of the dental school for which the license was issued, the licensee shall surrender the license, which shall be null and void upon termination of full-time employment. The dean of the dental school shall notify the board within five working days of such termination of full-time employment.

2. A full-time faculty licensee working in a faculty intramural clinic in a dental school may accept a fee for service.

D. A temporary permit, a teacher's license and a full-time faculty license may be revoked for any grounds for which the license of a regularly licensed dentist or dental hygienist may be revoked and for any act indicating the inability of the permittee or licensee to practice dentistry that is consistent with the protection of the public health and safety as determined by the generally accepted standards of dental practice in Virginia.

E. Applicants for a full-time faculty license or temporary permit shall be required to ~~pass an examination on~~ attest to having read and understand the laws and the regulations governing the practice of dentistry in Virginia.

18 VAC 60-20-105. Inactive license.

A. Any dentist or dental hygienist who holds a current, unrestricted license in Virginia may, upon a request on the renewal application and submission of the required fee, be issued an inactive license. The holder of an inactive license shall not be entitled to perform any act requiring a license to practice dentistry or dental hygiene in Virginia.

B. An inactive license may be reactivated upon submission of the required application, payment of the current renewal fee, and documentation of having completed continuing education hours equal to the requirement for the period of time immediately preceding the application for activation. In no event shall more than ~~three years~~ 45 hours of continuing education be required. The board reserves the right to deny a request for reactivation to any licensee who has been

determined to have committed an act in violation of § 54.1-2706 of the Code of Virginia.

PART IV. GENERAL ANESTHESIA AND CONSCIOUS, SEDATION AND ANALGESIA.

18 VAC 60-20-106. General provisions.

A. This part (18 VAC 60-20-106 et seq.) shall not apply to:

1. The administration of local anesthesia in dental offices; or
2. The administration of anesthesia in (i) a licensed hospital as defined in § 32.1-123 of the Code of Virginia or state-operated hospitals or (ii) a facility directly maintained or operated by the federal government.

B. Conscious sedation, deep sedation or general anesthesia shall not be provided in a dental office for patients in risk categories of Class IV and V, as classified by the American Society of Anesthesiologists (ASA). Patients in Class III shall only be provided anesthesia or sedation after consultation with their primary care physician or other medical specialist regarding potential risk and special monitoring requirements that may be necessary.

18 VAC 60-20-107. Administration of anxiolysis or inhalation analgesia.

A. Education and training requirements. A dentist who utilizes anxiolysis or inhalation analgesia shall have training in and knowledge of:

1. Medications used, the appropriate dosages and the potential complications of administration.
2. Physiological effects of nitrous oxide and potential complications of administration.

B. Equipment requirements. A dentist who utilizes anxiolysis or inhalation analgesia shall maintain the following equipment in his office and be trained in its use:

1. Blood pressure monitoring equipment.
2. Positive pressure oxygen.
3. Mechanical (hand) respiratory bag.

C. Monitoring requirements.

1. The treatment team for anxiolysis or inhalation analgesia shall consist of the dentist and a second person to assist, monitor and observe the patient.
2. A dentist who utilizes anxiolysis or inhalation analgesia shall ensure that a beginning and ending blood pressure has been taken and that there is continuous visual monitoring of the patient to determine the level of consciousness.
3. If inhalation analgesia is used, monitoring shall include making the proper adjustments of nitrous oxide machines at the request of the dentist during administration of the sedation and observing the patient's vital signs.

D. Discharge requirement. The dentist shall ensure that the patient is not discharged to his own care until he exhibits normal responses.

18 VAC 60-20-110. Requirements to administer deep sedation/general anesthesia.

A. Educational requirements. A dentist may employ or use deep sedation/general anesthesia on an outpatient basis by meeting one of the following educational criteria and by posting the educational certificate, in plain view of the patient, which verifies completion of the advanced training as required in subdivision 1 or 2 of this subsection. ~~The foregoing~~ These requirements shall not apply nor interfere with requirements for obtaining hospital staff privileges.

1. Has completed a minimum of one calendar year of advanced training in anesthesiology and related academic subjects beyond the undergraduate dental school level in a training program in conformity with published guidelines by the American Dental Association (Guidelines for Teaching the Comprehensive Control of Anxiety and Pain in Dentistry, effective October 1999), ~~which are incorporated by reference in this chapter in effect at the time the training occurred;~~ or

2. Completion of an American Dental Association approved residency in any dental specialty which incorporates into its curriculum the standards of teaching comparable to those set forth in published guidelines by the American Dental Association (Guidelines for Teaching the Comprehensive Control of Anxiety and Pain in Dentistry, effective October 1999), ~~which are incorporated by reference in this chapter in effect at the time the training occurred.~~

B. Additional training required. After March 31, 2005, dentists who administer deep sedation/general anesthesia shall hold current certification in Advanced Cardiac Life Support or Pediatric Advanced Life Support from the American Heart Association, current Drug Enforcement Administration registration, and training to the level consistent with Part I and Part II of the ADA guidelines for the use of conscious sedation, deep sedation and general anesthesia for dentists.

~~B. Exemptions~~ C. Exceptions.

1. A dentist who has not met the requirements specified in subsection A of this section may treat patients under deep sedation/general anesthesia in his practice if a qualified anesthesiologist, or a dentist who fulfills the requirements specified in subsection A of this section, is present and is responsible for the administration of the anesthetic.

2. If a dentist fulfills requirements ~~himself to use general anesthesia and conscious sedation specified in subsection A and B of this section,~~ he may employ the services of a certified nurse anesthetist.

D. Posting. Any dentist who utilizes deep sedation/general anesthesia shall post with the dental license and current registration with the Drug Enforcement Administration, the certificate of education required under subsections A and B of this section.

E. Emergency equipment and techniques. A dentist who administers deep sedation/general anesthesia shall be

proficient in handling emergencies and complications related to pain control procedures, including the maintenance of respiration and circulation, immediate establishment of an airway and cardiopulmonary resuscitation, and shall maintain the following emergency equipment in the dental facility:

1. Full face mask for children or adults, as appropriate for the patient being treated;

2. Oral and nasopharyngeal airways;

3. Endotracheal tubes for children or adults, or both, with appropriate connectors;

4. A laryngoscope with reserve batteries and bulbs and appropriately sized laryngoscope blades for children or adults, or both;

5. Source of delivery of oxygen under controlled positive pressure;

6. Mechanical (hand) respiratory bag;

7. Pulse oximetry and blood pressure monitoring equipment available and used in the treatment room;

8. Appropriate emergency drugs for patient resuscitation; and

9. EKG monitoring equipment and temperature measuring devices.

F. Monitoring requirements.

1. The anesthesia team for deep sedation/general anesthesia shall consist of the operating dentist, a second person to monitor and observe the patient and a third person to assist the operating dentist.

2. Monitoring of the patient under deep sedation/general anesthesia is to begin immediately after the patient has been induced and a maintenance level has been established and shall take place continuously during the dental procedure. The person who administered the anesthesia must remain on the premises of the dental facility until the patient has regained consciousness and is discharged.

3. Monitoring deep sedation/general anesthesia shall include the following: recording and reporting of blood pressure, pulse, respiration and other vital signs to the attending dentist.

18 VAC 60-20-120. Requirements to administer conscious sedation; intravenous and intramuscular.

A. Automatic qualification. Dentists qualified to administer deep sedation/general anesthesia may administer conscious sedation.

B. Educational requirements for administration of conscious sedation by any method. A dentist may employ or use any method of conscious sedation by meeting one of the following criteria:

1. A dentist may administer conscious sedation upon completion of training for this treatment modality according to guidelines published by the American Dental Association

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(Guidelines for Teaching the Comprehensive Control of Anxiety and Pain in Dentistry, effective October 1999) and incorporated by reference in this chapter in effect at the time the training occurred, while enrolled at an approved accredited dental school program or while enrolled in a post-doctoral university or teaching hospital program; or

2. A dentist who was self-certified in anesthesia and conscious sedation prior to January 1989 may continue to administer conscious sedation if he completes 12 hours of approved continuing education directly related to administration of conscious sedation by March 31, 2005. A dentist qualified to administer conscious sedation by a certificate issued by the board shall maintain documentation of the required continuing education.

C. Educational requirement for enteral administration of conscious sedation only. A dentist may administer conscious sedation by an enteral method if he has completed a program of not less than 40 hours of clinical training for this treatment modality according to the guidelines published by the American Dental Association (Guidelines for Teaching the Comprehensive Control of Anxiety and Pain in Dentistry) in effect at the time the training occurred.

D. Additional training required. After March 31, 2005, dentists who administer conscious sedation shall hold current certification in Advanced Cardiac Life Support from the American Heart Association as evidenced by a certificate posted with the dental license and current registration with the Drug Enforcement Administration.

E. Emergency equipment and techniques. A dentist who administers conscious sedation shall be proficient in handling emergencies and complications related to pain control procedures, including the maintenance of respiration and circulation, immediate establishment of an airway and cardiopulmonary resuscitation, and shall maintain the following emergency airway equipment in the dental facility:

1. Full face mask for children or adults, as appropriate for the patient being treated;
2. Oral and nasopharyngeal airways;
3. Endotracheal tubes for children or adults, or both, with appropriate connectors;
4. A laryngoscope with reserve batteries and bulbs and appropriately sized laryngoscope blades for children or adults, or both;
5. Source of delivery of oxygen under controlled positive pressure;
6. Mechanical (hand) respiratory bag; and
7. Appropriate emergency drugs for patient resuscitation.

F. Monitoring requirements.

1. The treatment team for conscious sedation shall consist of the operating dentist and a second person to assist, monitor and observe the patient.
2. Monitoring of the patient under conscious sedation is to take place continuously during the dental procedure. The

person who administers the sedation must remain on the premises of the dental facility until the patient is responsive and is discharged.

18 VAC 60-20-130. General information. (Repealed.)

~~A. Emergency equipment and techniques. A dentist who administers general anesthesia and conscious sedation (excluding nitrous oxide) shall be proficient in handling emergencies and complications related to pain control procedures, including the maintenance of respiration and circulation, immediate establishment of an airway and cardiopulmonary resuscitation, and shall maintain the following emergency airway equipment in the dental facility:~~

- ~~1. Full face mask for children or adults, or both;~~
- ~~2. Oral and nasopharyngeal airways;~~
- ~~3. Endotracheal tubes for children or adults, or both, with appropriate connectors;~~
- ~~4. A laryngoscope with reserve batteries and bulbs and appropriately sized laryngoscope blades for children or adults, or both;~~
- ~~5. Source of delivery of oxygen under controlled pressure; and~~
- ~~6. Mechanical (hand) respiratory bag.~~

~~B. Posting requirements. Any dentist who utilizes general anesthesia or conscious sedation shall post in each facility the certificate of education required under 18 VAC 60-20-110 A and 18 VAC 60-20-120 B or a certificate issued by the board.~~

~~C. Other.~~

- ~~1. The team for general anesthesia shall consist of the operating dentist, a second person to monitor and observe the patient, and a third person to assist the operating dentist.~~
- ~~2. The person in charge of the anesthesia must remain on the premises of the dental facility until the patient has regained consciousness and is discharged.~~

~~D. Scope of regulation. Part IV (18 VAC 60-20-110 et seq.) of this chapter shall not apply to administration of general anesthesia and conscious sedation in hospitals and surgical centers.~~

18 VAC 60-20-135. Ancillary personnel.

After March 31, 2005, dentists who employ ancillary personnel to assist in the administration and monitoring of any form of conscious sedation or deep sedation/general anesthesia shall maintain documentation that such personnel have:

1. Minimal training resulting in current certification in Basic Cardiac Life Support from the American Heart Association and an approved, clinically oriented course devoted primarily to responding to clinical emergencies offered by an approved provider of continuing education as set forth in 18 VAC 60-20-50 C; or
2. Current certification as a certified anesthesia assistant (CAA) by the American Association of Oral and Maxillofacial

Surgeons or the American Dental Society of Anesthesiology (ADSA).

18 VAC 60-20-195. Radiation certification.

No person not otherwise licensed by this board shall place or expose dental x-ray film unless he has (i) satisfactorily completed a course or examination recognized by the Commission on Dental Accreditation of the American Dental Association, (ii) been certified by the American Registry of Radiologic Technologists, (iii) satisfactorily completed a course and passed an examination in compliance with guidelines provided by the board, or (iv) ~~passed the board's examination in radiation safety and hygiene followed by on-the-job training. Any individual not able to successfully complete the board's examination after two attempts may be certified only by completing (i), (ii) or (iii) of this provision satisfactorily completed a radiation course and passed an examination given by the Dental Assisting National Board.~~ Any certificate issued pursuant to satisfying the requirements of this section shall be posted in plain view of the patient.

DOCUMENTS INCORPORATED BY REFERENCE

~~Guidelines for Teaching the Comprehensive Control of Anxiety and Pain in Dentistry (October 1999), American Dental Association.~~

1995 Current Dental Terminology, Second Edition, 1995-2000, Code on Dental Procedures and Nomenclature, American Dental Association.

Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental Specialists, October 1995, American Dental Association.

VA.R. Doc. No. R02-176; Filed December 9, 2004, 3:04 p.m.

DEPARTMENT OF HEALTH PROFESSIONS

Title of Regulation: **18 VAC 76-40. Regulations Governing Emergency Contact Information (adding 18 VAC 76-40-10, 18 VAC 76-40-20, and 18 VAC 76-40-30).**

Statutory Authority: § 54.1-2506.1 of the Code of Virginia.

Public Hearing Date: January 23, 2004 - 9 a.m.

Public comments may be submitted until February 27, 2004.
(See Calendar of Events section
for additional information)

Agency Contact: Elaine J. Yeatts, Agency Regulatory Coordinator, Department of Health Professions, 6603 West Broad Street, 5th Floor, Richmond, VA 23230, telephone (804) 662-9918, FAX (804) 662-9114, or e-mail elaine.yeatts@dhp.state.va.us.

Basis: Section 54.1-2506.1 of the Code of Virginia mandates the Director of the Department of Health Professions, in consultation with the Department of Health and the Department of Emergency Management, to adopt regulations that identify those licensed, certified or registered persons to which the requirement to report information about a public health emergency shall apply and the procedures for reporting.

Purpose: The purpose of these regulations is to set out the listing of licensees, certificate holders, and registrants that are required to provide contact numbers and email addresses that may be used in the event of a public health emergency to disseminate information to health care providers and to request mobilization of those providers needed to deliver services in an affected area of the state. Phone numbers, fax numbers and email addresses will be collected from those who list Virginia as their address of record, as well as those from contiguous states and the District of Columbia. The Department of Health Professions must collect the data that is maintained in a web-based system and available for use by the Department of Health in the event of a public health emergency. In such an event, expedited notification to health care professionals giving them vital instruction and information could be crucial to public health and safety. Also, the Emergency Contact Information system may be activated in order to mobilize a volunteer workforce of health professionals who could report to an affected area of the state.

Substance: Proposed regulations list those categories of regulated entities that will be required to provide emergency contact information and limits that requirement to those persons or entities whose address of record is in Virginia, a contiguous state or the District of Columbia. The contact information required to be reported is set forth in regulation, along with the time frame within the regulant is expected to respond. Regulated entities are only required to provide fax numbers or email addresses if they have direct access to such, and all collected information may be only used for the purpose of disseminating notification of a public health emergency. After the initial data collection, the regulants will be asked to update their information on a renewal application and whenever there is a change in the contact information provided to the department.

Issues: The primary advantage to the public of implementing these provisions is the ability to have a notification system in place in the event of a public health emergency. By being able to provide immediate, reliable information to health care workers, a vital, appropriate response to an emergency may be expedited. There are no disadvantages to the public or to licensees. Emergency contact information is not subject to the Freedom of Information Act, so private numbers and email addresses are protected.

The advantage to the Commonwealth is the facilitation of emergency management planning. With a database of emergency contact numbers, response time to a public health emergency should be greatly reduced and much more effective. There are no disadvantages; the Department of Health has secured a federal grant from which the initial cost of creating the database and collecting the information is to be paid.

Department of Planning and Budget's Economic Impact Analyses: The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with Section 2.2-4007 H of the Administrative Process Act and Executive Order Number 21 (02). Section 2.2-4007 H requires that such economic impact analyses include, but need not be limited to, the projected number of businesses or other entities to whom the regulation would

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apply, the identity of any localities and types of businesses or other entities particularly affected, the projected number of persons and employment positions to be affected, the projected costs to affected businesses or entities to implement or comply with the regulation, and the impact on the use and value of private property. The analysis presented below represents DPB's best estimate of these economic impacts.

Summary of the proposed regulation. Chapter 602 of the 2003 Acts of the Assembly requires the Department of Health Professions (department), in consultation with the Department of Health and the Department of Emergency Management, to adopt regulations for the collection of emergency contact information to be used to notify health professionals in the event of a public health emergency. The department proposes regulations that identify those licensed, certified or registered persons to which the requirement to report shall apply, the information to be reported and the procedures and time limits for reporting.

Estimated economic impact. The Department of Health and the Department of Emergency Management provided the categories of professionals and entities from which contact information is needed in case of a public health emergency. The list includes: (i) certified massage therapists, (ii) clinical psychologists, (iii) clinical social workers, (iv) dentists, (v) funeral service licensees, embalmers and funeral directors, (vi) licensed acupuncturists, (vii) licensed practical nurses, (viii) licensed professional counselors, (ix) medical equipment suppliers, (x) pharmacists, (xi) pharmacy technicians, (xii) physical therapists, (xiii) physician assistants, (xiv) radiologic technologists, (xv) registered nurses, (xvi) respiratory care practitioners, (xvii) surface transportation and removal service registrants, (xviii) veterinarians, and (xix) wholesaler distributors of pharmaceuticals. Doctors of medicine, osteopathy, and podiatry are not on the list since they already provide such information through a previous legislative mandate.

The proposed regulations specify that "Upon a request from the [department], a person or entity [listed above] shall be required to report the following information for contact in the event of a public health emergency:

1. A telephone number at which he may be contacted during weekday business hours (8 a.m. to 5 p.m.);
2. A telephone number at which he may be contacted during nonbusiness hours (5 p.m. to 8 a.m. weekdays and on weekends or holidays);
3. A fax number at which he may be sent information concerning the emergency; and
4. An email address at which he may be sent information concerning the emergency."

On the other hand, the department states in the Proposed Regulation Agency Background Document that it "does not anticipate initiating an enforcement proceeding against

practitioners who fail to respond at this time. In addition, no one will be denied licensure renewal for failure to comply."¹

Also, the department states in the Proposed Regulation Agency Background Document that "The practitioner will also be asked whether he would be willing to volunteer for medical response during a bioterrorism event or any other public health emergency..." Combining the collection of emergency contact information with information on whether the practitioner is willing to volunteer for medical response during public health emergencies will be beneficial. Practitioners who are interested and able to respond on short notice to emergency situations will be more easily identified and contacted quickly. This will likely provide faster medical response.

The department projects that the initial cost to implement the collection of emergency contact information from the approximately 144,000 affected practitioners is \$201,901. Approximately half of this expenditure will be reimbursed through a federal grant.² Whether or not a net benefit is created for the Commonwealth depends on how much faster medical responses will be, and how much those faster responses are valued. The net value of the proposal will be greater if practitioners are made aware that providing emergency contact information is in practice voluntary. Forcing practitioners who do not intend to volunteer to provide emergency contact information is a waste of time and resources for the practitioners and the Commonwealth.

The proposed regulation affects the 3,165 certified massage therapists, 1,914 clinical psychologists, 3,848 clinical social workers, 4,627 dentists, 1,520 funeral service licensees, embalmers and funeral directors, 184 licensed acupuncturists, 26,252 licensed practical nurses, 2,431 licensed professional counselors, 256 medical equipment suppliers, 1,151 pharmacy technicians, 7,097 pharmacists, 3,927 physical therapists, 879 physician assistants, 2,323 radiologic technologists, 77,629 registered nurses, 2,851 respiratory care practitioners, 43 surface transportation and removal service registrants, 2,577 veterinarians, and 172 wholesaler distributors of pharmaceuticals that whose address of record is in Virginia or a contiguous state.

Localities particularly affected. The proposed regulations affect all Virginia localities.

Projected impact on employment. The proposed amendments will not affect employment levels.

Effects on the use and value of private property. The proposed amendments will not affect the use and value of private property.

Agency Response to Economic Impact Analysis: The Department of Health Professions concurs with the analysis of the Department of Planning and Budget for proposed regulations, 18 VAC 76-40, for the collection of emergency contact information.

¹ The Department of Health Professions also confirmed via phone conversation that the requirement to provide emergency contact information will not be enforced.

² Source: Department of Health Professions

Summary:

Chapter 602 of the 2003 Acts of Assembly requires the Director of the Department of Health Professions, in consultation with the Department of Health and the Department of Emergency Management, to adopt regulations that identify those licensed, certified or registered persons to which the requirement to report shall apply and the procedures for reporting. The proposed regulations list those categories of regulated entities that will be required to provide emergency contact information and limits that requirement to those persons or entities whose address of record is in Virginia, a contiguous state or the District of Columbia. The contact information required to be reported is set forth in, along with the time frame within which the regulant is expected to respond. Regulated entities are only required to provide fax numbers or e-mail addresses if they have direct access to such, and all collected information may be only used for the purpose of disseminating notification of a public health emergency.

CHAPTER 40.
REGULATIONS GOVERNING EMERGENCY CONTACT
INFORMATION.

18 VAC 76-40-10. Requirement to report.

In accordance with provisions of § 54.1-2506.1 of the Code of Virginia, the following persons or entities who hold a license, certificate, registration or permit issued by a board within the Department of Health Professions and whose address of record is in Virginia, a contiguous state or the District of Columbia shall report emergency contact information as required by this chapter:

1. Certified massage therapists;
2. Clinical psychologists;
3. Clinical social workers;
4. Dentists;
5. Funeral service licensees, embalmers and funeral directors;
6. Licensed acupuncturists;
7. Licensed practical nurses;
8. Licensed professional counselors;
9. Medical equipment suppliers;
10. Pharmacists;
11. Pharmacy technicians;
12. Physical therapists;
13. Physician assistants;
14. Radiologic technologists;
15. Registered nurses;
16. Respiratory care practitioners;
17. Surface transportation and removal service registrants;
18. Veterinarians; and

19. Wholesaler distributors of pharmaceuticals.

18 VAC 76-40-20. Emergency contact information.

A. Upon a request from the department, a person or entity listed in 18 VAC 76-40-10 shall be required to report the following information for contact in the event of a public health emergency:

1. A telephone number at which he may be contacted during weekday business hours (8 a.m. to 5 p.m.);
2. A telephone number at which he may be contacted during nonbusiness hours (5 p.m. to 8 a.m. weekdays and on weekends or holidays);
3. A fax number at which he may be sent information concerning the emergency; and
4. An e-mail address at which he may be sent information concerning the emergency.

B. A person or entity shall only be required to report those fax numbers or e-mail addresses to which he has direct access.

C. Information collected for the purpose of disseminating notification of a public health emergency shall not be published or made available for any other purpose.

18 VAC 76-40-30. Time limit for reporting.

A licensee, certificate or permit holder or registrant shall provide the required emergency contact information within a time period specified by the Director of the Department of Health Professions to be no less than 30 days or greater than 90 days from receipt of the request or notification from the department. Whenever there is a change in the information that has been provided, the licensee, certificate or permit holder or registrant shall provide revised information to the department within 30 days.

<p>NOTICE: The form used in administering 18 VAC 76-40, Regulations Governing Emergency Contact Information, is listed and published below.</p>
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FORMS

Emergency Contact Information (eff. 8/03)

Proposed Regulations



Department of Health Professions
Commonwealth of Virginia

6603 West Broad Street – 5th Floor
Richmond, Virginia 23230-1712

(804) 662-9919

Emergency Contact Information

In order to expedite the dissemination of information to health care practitioners about a public health emergency, the Department requests that you provide the following information if you reside in Virginia, one of the adjacent states or the District of Columbia:

A telephone number at which you can be contacted during weekday business hours (8:00 am – 5:00 pm)

A telephone number at which you can be contacted during non-business hours (5:00 pm – 8:00 am on weekdays and on weekends or holidays)

A fax number at which you may be sent information about the emergency*

An email address at which you may be sent information about the emergency*

**This information is not required if you do not have direct access to a fax or email address.*

Would you be willing to volunteer your services if there is a public health emergency in Virginia?

Yes _____ No _____

The information collected by the Department of Health Professions for emergency contact may only be used to notify practitioners of a public health emergency. The law prohibits publication, disclosure or use of this information for any other purpose.

8/03

VA.R. Doc. No. R03-314; Filed December 9, 2003, 2:53 p.m

BOARD OF NURSING

Title of Regulation: 18 VAC 90-20. Regulations Governing the Practice of Nursing (amending 18 VAC 90-20-10, 18 VAC 90-20-35, 18 VAC 90-20-40, 18 VAC 90-20-50, 18 VAC 90-20-60, 18 VAC 90-20-90, 18 VAC 90-20-95, 18 VAC 90-20-120, 18 VAC 90-20-140, 18 VAC 90-20-160, 18 VAC 90-20-170, 18 VAC 90-20-190, 18 VAC 90-20-200, 18 VAC 90-20-220, 18 VAC 90-20-230, 18 VAC 90-20-270, 18 VAC 90-20-280, 18 VAC 90-20-300, 18 VAC 90-20-390, 18 VAC 90-20-410, 18 VAC 90-20-460; adding 18 VAC 90-20-65; repealing 18 VAC 90-20-310 through 18 VAC 90-20-360).

Statutory Authority: § 54.1-2400 of the Code of Virginia.

Public Hearing Date: January 27, 2004 - 11 a.m.

Public comments may be submitted until February 27, 2004.
(See Calendar of Events section for additional information)

Agency Contact: Elaine J. Yeatts, Agency Regulatory Coordinator, Department of Health Professions, 6603 West Broad Street, 5th Floor, Richmond, VA 23230, telephone (804) 662-9918, FAX (804) 662-9114, or e-mail elaine.yeatts@dhp.state.va.us.

Basis: Section 54.1-2400 of the Code of Virginia establishes the general powers and duties of health regulatory boards including the responsibility to promulgate regulations, levy fees, administer a licensure and renewal program, and discipline regulated professionals.

Statutes governing the practice of nursing are found in Chapter 30 (§ 54.1-3000 et seq.) of Title 54.1 of the Code of Virginia.

Purpose: Through a review of its regulations, the board has determined that clarifications were necessary or, in some cases, the rule needed to be made more specific to address an identified problem. To ensure consistency and compliance with standards set for board approval of nursing education programs, the board has added more specificity to the current rules. Changes in the application process for an educational program are intended to ensure that a program has the resources and facilities to be viable and adequately prepare students for examination and safe practice.

Changes in the reporting requirements will ensure that the board is promptly informed when there is a significant event that may jeopardize the ability of the program to educate its students. With proposed regulations, continued approval of a program may be based on evidence of accreditation by a nursing education accrediting body. Elimination of duplicate submissions and site visits will conserve resources for educational programs that may better be used within the program or supporting institution. By specifying the educational credentials of program directors and faculty, the board is addressing the need to clarify that nursing programs have regulatory standards consistent with those required for accreditation. Nursing students who are educated by faculty whose degrees are in nursing are likely to be more adequately prepared for an increasingly complex practice environment. Additions to the curriculum, including topics such as patient rights and the definition of patient abuse and abandonment,

are designed to better prepare the licensed nurse and protect the health, safety and welfare of the patient.

In the last 20 years, the increases in acuity and sophistication of nursing care have demanded better prepared nurses with knowledge and critical thinking processes to function safely in health care environments and to communicate with other health care providers. This in turn demands better educational preparation for all faculty to teach these nurses, and the majority of that preparation must be in nursing. Thus the proposed amendments to faculty qualifications are needed to ensure that graduates of nursing education programs are prepared for safe and effective nursing practice.

Clarification of authorization to practice while awaiting licensure will protect the applicant from inadvertently practicing illegally, and a more specific requirement for evidence of continuing competency for a nurse who has been out of practice and is seeking reinstatement will offer greater protection to patients. Likewise, a specific number of hours in classroom instruction and practice for medication administration by unlicensed individuals is intended to protect the health and safety of the public who rely on the knowledge and ability of these persons for accurate administration of prescription drugs.

Substance: The Board of Nursing is proposing that 18 VAC 90-20 be amended to clarify regulations that have been confusing to applicants, regulants or educational programs. Amendments to the nursing and nurse aide education program address concerns about the quality of instruction, the reporting of changes in the program, and other issues related to meeting the educational needs of students. To ease the burden of nursing education programs that undergo extensive review for accreditation by a national nursing credentialing body, it is proposed to allow acceptance of that accreditation for the purpose of continued approval by the board.

Additional requirements are proposed to provide specificity about evidence of continued competency necessary for reinstatement of a license, to provide certain grounds for disciplinary action for the protection of patients or clients, to specify the number of hours of training necessary in a medication administration training program, to update the protocol for adult immunizations, and to state in regulation a policy of the board on the delegation of tasks in an operating room.

The regulations that address criteria for approval of nurse aide education programs and certification of nurse aides are being repealed and set forth in another set of regulations adopted by the board.

Issues: Advantages or disadvantages to the public: The public will directly benefit from a more specific requirement on nametags; people who interact with nurses in a practice setting will be able to identify the nurse providing care and his/her level of licensure. Indirectly, there is an advantage to the public from having nurses educated by more qualified instructors in several new topics that directly relate to patient care. The addition of grounds for disciplinary action will ensure that the board has the ability to discipline a nurse who has violated the rights or property of a patient. Finally, the public will benefit from a specific number of hours required for

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medication administration training and from a prohibition against delegation of circulating duties in an operating room to an unlicensed individual.

Advantages or disadvantages to the agency: There are no specific advantages or disadvantages to the agency or the Commonwealth. More specificity in the rules may alleviate questions and misunderstandings by educational programs and licensees, but there should be no additional cost for enforcement. The agency may experience a reduction in the number of hours required for program reviewers to conduct site visits, which could result in a moderate reduction in that line item in the budget of the board.

Department of Planning and Budget's Economic Impact Analysis: The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with § 2.2-4007 H of the Administrative Process Act and Executive Order Number 21 (02). Section 2.2-4007 H requires that such economic impact analyses include, but need not be limited to, the projected number of businesses or other entities to whom the regulation would apply, the identity of any localities and types of businesses or other entities particularly affected, the projected number of persons and employment positions to be affected, the projected costs to affected businesses or entities to implement or comply with the regulation, and the impact on the use and value of private property. The analysis presented below represents DPB's best estimate of these economic impacts.

Summary of the proposed regulation. The Board of Nursing (board) proposes to: (i) amend these regulations so as to allow itself to accept evidence of accreditation by a nursing education accrediting body for the purpose of continued approval of a nursing program, (ii) change required faculty qualifications for nursing programs, (iii) change required curriculum for nursing programs, (iv) require that education programs notify the board within 10 days if there is a change in their program director, governing body, or accreditation status, (v) require that nurses who have had their license lapse for more than one year complete 15 hours of continuing education in nursing or pass the National Council Licensing Examination during the period the Virginia license lapsed in order to have their license reinstated, (vi) add to the list actions that are specified as unprofessional conduct, (vii) delete the regulatory language pertaining to certified nurse aides, (viii) establish a required minimum number of hours (24) to be spent on classroom instruction and practice in the content requirements for medication administration training programs, and (ix) add clarifying language in several areas.

Estimated economic impact. Accreditation in lieu of site visit. Under the current regulations, Department of Health Professions (department) staff conduct survey visits of nursing education programs every eight years in order to evaluate whether the programs should continue to hold approved status. According to the department, the information gathered by their site visits greatly overlaps with information obtained by accrediting bodies on their site visits. The proposed regulations allow the board to accept evidence of accreditation by a nursing education accrediting body recognized by the U.S. Department of Education for the purpose of continued approval of a program in lieu of a site visit. Under both the

current and proposed regulations, programs must submit a comprehensive self-evaluation report.

This proposed amendment produces significant cost savings for both nursing education programs and the department. For example, Associate Dean Janet Younger of the Virginia Commonwealth University School of Nursing estimates that the following staff time is spent in connection with department site visits:

Preparation for visit:

4 days full time by 1 secretary (approximate \$30,000 annual salary)¹

4 days full time by 1 dean-level staff member (\$100,000 to \$140,000 annual salary)

20 minutes of preparation by all 36 faculty (average faculty salary: \$80,000)

Visit:

2 days full time by 1 dean (\$100,000 to \$140,000 annual salary)

2 days full time by 2 faculty (approx. \$80,000 annual salary)

2 days full time by 1 secretary (approx. \$30,000 annual salary)

2 hours with each faculty member (approx. \$80,000 annual salary)

1 hour each with 12 provost, vice-president, dean-level staff (\$100,000 to \$170,000 annual salary)

Combining the above information with assumptions of a 40-hour work week and a 50-week work year, the estimated savings for VCU by eliminating a site visit is \$8,890² in personnel time every eight years. Material costs are minimal.³ According to the department, there are 96 nursing education programs (38 in registered nursing and 58 in licensed practical nursing) in the Commonwealth. The proposal to accept national accreditation in lieu of a site visit primarily affects the 38 registered nurse programs because they are mainly the ones that have national accreditation; 36 out of 38 registered nursing programs in Virginia hold national accreditation. The two programs that are not yet accredited have been recently established and are undergoing the approval process with the board as well as the accrediting process. Smaller programs may incur smaller costs in personnel time spent in connection

¹ All salary estimates were provided by VCU.

² Calculations: $40 \times 50 = 2,000$ hours in a work year; $32 / 2,000 = 0.016$ (4 days' percentage of work year); $\$30,000 \times 0.016 = \480 (value of secretary's four days of preparation); $\$120,000 \times 0.016 = \$1,920$ (value of dean-level staff member's four days of preparation); $(1/3) / 2,000 = 0.000167$ (20 minutes' percentage of work year); $36 \times \$80,000 \times 0.000167 = \480 (value of 36 professors' 20 minutes of preparation); $16 / 2,000 = 0.008$ (2 days' percentage of work year); $\$120,000 \times 0.008 = \960 (value of dean's two days during visit); $2 \times \$80,000 \times 0.008 = \$1,280$ (value of two professors' two days during visit); $\$30,000 \times 0.008 = \240 (value of secretary's two days during visit); $2 / 2,000 = 0.001$ (two hours' percentage of work year); $34 \times \$80,000 \times 0.001 = \$2,720$ (value of 34 faculty members' two hours during visit); $1 / 2,000 = 0.0005$ (1 hour's percentage of work year); $12 \times \$135,000 \times 0.0005 = \810 (value of twelve provost, vice-president, dean-level staff's one hour during visit); $\$480 + \$1,920 + \$480 + \$960 + \$1,280 + \$240 + \$2,720 + \$810 = \$8,890$ (value of personnel time spent on site visit).

³ Source: Associate Dean Janet Younger of the Virginia Commonwealth University School of Nursing

with site visits. Nevertheless, the potential aggregate savings for Virginia's nursing education programs is large.

The department would also save on expenses by acceptance of the report for national accreditation in lieu of the once every eight-year site visit. Depending on the content of the report filed with the board, it retains the option of a site visit but would not be required to do so if the program has maintained accreditation. The department estimates that the revised regulation may result in four less site visits by staff each year for a total savings of approximately \$1,410 per year.⁴

The department is confident that it will receive sufficient information through receipt of the most recent report from the applicable accrediting agency as well the comprehensive self-evaluation report to determine whether a nursing program shall be qualified to continue to receive approved status. Given the significant cost savings for both nursing education programs and the department and the continued receipt of adequate information for judgment by the department, the proposal to allow the board to accept evidence of accreditation by a nursing education accrediting body recognized by the U.S. Department of Education for the purpose of continued approval of a program in lieu of a site visit produces a net benefit for the Commonwealth.

Faculty qualifications for nursing programs. The board proposes to amend the required minimum faculty qualifications for nursing programs. According to the department, all of the proposed amendments are consistent with requirements to achieve accreditation. The proposed regulations also include "grandfathering language" that exempts faculty hired prior to the effective date of the proposed regulations from the new educational requirements.

Program directors of baccalaureate degree programs in nursing are currently required to have a doctorate. The regulations do not specify that the PhD be in any particular field. The proposed regulations maintain the doctorate requirement without specifying a field, but also require that the program director have at least one graduate degree in nursing. Program directors with a PhD in nursing or a PhD in another field and a master's degree in nursing will not be affected by this proposed amendment. Directors with a PhD in a nonnursing field and who possess no graduate nursing degree will not be eligible for program director positions under the proposed regulations.

Faculty of baccalaureate degree programs in nursing are currently required to have a graduate degree. If the graduate degree is in something other than nursing, then their baccalaureate degree must be in nursing. Under the proposed regulations, faculty of baccalaureate degree programs in nursing are required to have a graduate degree in nursing, or another graduate degree with at least 18 graduate credit hours in nursing.

Under the current regulations, program directors of associate degree programs in nursing and the majority of the faculty are required to have a graduate degree. Other faculty members,

both full-time and part-time, must have at least a baccalaureate degree. The degree may be in any field. The proposed regulations specify that the director's graduate degree must be in nursing and that every full-time faculty member must hold either a graduate degree in nursing or another graduate degree with at least 18 graduate credit hours in nursing. Part-time clinical members of the faculty must have at least a baccalaureate degree.

The proposed amendments to the required minimum faculty qualifications in registered nursing programs will not have an immediate impact since the proposed requirements are commensurate with requirements for accreditation, and all registered nursing programs in the Commonwealth are either accredited or are currently undergoing the accrediting process.⁵ However, Virginia law does not prohibit registered nursing programs from operating without accreditation, nor does it prohibit individuals who earn a degree at an unaccredited registered nursing program from working as registered nurses in Virginia. The proposed increase in the required minimum faculty qualifications in registered nursing programs could discourage the establishment of nonaccredited registered nursing programs in the Commonwealth.

For practical nursing programs, the program director and the majority of the faculty must have at least a baccalaureate degree. The degree may be in any field. Under the proposed regulations, the director must have a baccalaureate degree in nursing. The requirement that the majority of the faculty have at least a baccalaureate degree in any field is not changed. Read literally, the requirement that the program director have a baccalaureate degree in nursing disqualifies an individual with a graduate degree in nursing, but an undergraduate degree in another field, from the position. Prohibiting such individuals from becoming directors is costly to both the individuals and the programs since the programs will no longer be permitted to consider potentially very capable candidates for the position. Holding other factors constant, a graduate degree in nursing demonstrates greater relevant knowledge than a baccalaureate degree. This will drive up hiring costs for the programs. There is no apparent benefit to prohibiting candidates with a graduate degree in nursing, but an undergraduate degree in another field, from qualifying to be a director of a practical nursing program.

The proposal to require that the director's baccalaureate degree be in nursing also disqualifies candidates who possess no degree in nursing from the position. Since this also prevents programs from considering candidates that they may consider under the current regulations, it also adds to programs' costs. On the other hand, holding other factors constant, no degree in nursing demonstrates less relevant knowledge than a baccalaureate degree in nursing. Thus, preventing individuals with no baccalaureate or higher degree in nursing from becoming director of a practical nursing program can be beneficial in that the public is assured that such programs have a director with relevant knowledge at

⁴ The Department of Health Professions estimates that it will save \$352.50 for each time that it accepts the report for national accreditation in lieu of a site visit. Calculation: 4 x \$352.50 = \$1,410

⁵ According to the Department of Health Professions, 36 out of 38 registered nursing programs in Virginia hold national accreditation; and the other two programs have been recently established and are undergoing the accrediting process.

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least commensurate with that gained from a baccalaureate degree in nursing.

Notification of program changes. The board proposes to require education programs to notify the board within 10 days if there is a change to any of the following: the program director, the governing body of a program, or the accreditation status of a program. Under the current regulations changes only need to be reported once a year in the program's annual report. According to the department, the education programs may notify the board via email, letter, or fax. Thus, the education programs' costs of sending notification are small. The value to the board of having accurate up-to-date information likely exceeds the small cost of sending notification.

Continuing education for licensure reinstatement. The board proposes to require that nurses who have had their license lapse for more than one year complete 15 clock hours of continuing education in nursing or pass the National Council of State Boards of Nursing licensing examination during the period the Virginia license lapsed in order to have their license reinstated. The continuing education must be in nursing and be provided by a regionally accredited educational institution or a professional nursing organization. The board may waive all or part of the continuing education requirement for a nurse who holds a current, unrestricted license in another state and who has engaged in active practice during the period the Virginia license was lapsed. There are no continuing education requirements for nurses who apply to renew their license on time.

According to the department, most nurses already obtain continuing education through in-service training in their employment setting. The proposed continuing education requirement will not affect these individuals if their annual in-service training equals or exceeds 15 hours. For those nurses who seek to reinstate their lapsed license who do not already obtain 15 hours of continuing education through in-service training, the American Nurses Association (ANA) offers continuing education courses in nursing online.⁶ Currently, 7.2 hours are available at no cost to both members and nonmembers. ANA members can complete the remaining required 7.8 hours through ANA online courses for \$28 in fees. For nonmembers the cost is \$43. The annual ANA membership fee for Virginians is \$225.⁷ As stated above, instead of 15 hours of continuing education, the proposed requirement may alternatively be met by passing the National Council of State Boards of Nursing licensing examination. Exam takers must pay a \$200 fee to the National Council and a \$25 fee to the Virginia Board of Nursing. Thus, for those individuals seeking the lowest cost means of compliance, the proposed continuing education requirement will not cost individuals more than \$43 in terms of fees.

In addition to fees, nurses' time also has value. The median hourly wages for registered nurses and licensed practical nurses in Virginia are \$21.03 and \$14.09, respectively.⁸

Assuming that the value of a nurse's time is equal to her median hourly wage, then it would cost a registered or licensed practical nurse who is neither currently obtaining any continuing education nor is a member of ANA \$358.45⁹ or \$254.35,¹⁰ respectively, to comply with the proposed license reinstatement continuing education requirement. The cost is lower for individuals who either currently receive some continuing education or are members of ANA.

The benefit of the proposed continuing education requirement is more difficult to estimate than the cost. Since the continuing education hours must be in nursing, nurses who take the courses likely gain some useful knowledge. Nevertheless, the amount of useful nursing-related knowledge that is gained, i.e., not already known by the nurses, is not evident. Plus, it is not clear whether the additional knowledge makes a significant difference in the competence of the nurses concerned.

Certified nurse aides. The board proposes to repeal the regulatory language concerning certified nurse aides. New regulation, 18 VAC 90-25, is currently proposed that will contain an amended version of the regulatory language concerning certified nurse aides that is currently in these regulations. Analysis of the proposed amendments to certified nurse aide regulation is contained within the Economic Impact Analysis for those proposed regulations.

Medication administration training programs. The current regulations include subject matter requirements for medical administration training programs, but do not specify a minimum amount of time to be spent on classroom instruction and practice. The board proposes to require that medical administration training programs consist of at least 24 hours of classroom instruction and practice. The board believes that appropriate training cannot be fully delivered in less than 24 hours. Since all approved medication administration training programs in Virginia currently meet this minimum requirement,¹¹ this proposal will have no immediate impact.

Businesses and entities affected. The proposed amendments affect the 84,675 registered nurses, 26,679 licensed practical nurses, and 451 clinical nurse specialists in the Commonwealth, as well as their patients and employers. In addition, the 38 registered nurse programs, the 58 licensed practical nurse programs, and their staff and students are affected as well.

Localities particularly affected. The proposed regulations affect all Virginia localities.

Projected impact on employment. The proposed requirement that the director of practical nursing programs have a baccalaureate degree in nursing may alter who is hired by such programs.

Effects on the use and value of private property. The proposal to allow the board to accept evidence of accreditation by a nursing education accrediting body recognized by the U.S. Department of Education for the purpose of continued

⁶ See <http://nursingworld.org/ce/cecatalog.cfm>

⁷ The annual membership fee for ANA differs by state.

⁸ Source: U.S. Department of Labor, Bureau of Labor Statistics, 2001 State Occupational Employment and Wage Estimates

⁹ Calculation: $\$43 + (15 \times \$21.03) = \$358.45$

¹⁰ Calculation: $\$43 + (15 \times \$14.09) = \$254.35$

¹¹ Source: Department of Health Professions

approval of a program in lieu of a site visit will save nursing programs thousands of dollars in costs. The value of these programs will increase commensurately.

The requirement that directors of practical nursing programs have a baccalaureate degree in nursing increases hiring costs for such programs, consequently lowering their value by a small amount.

The proposed requirement that nurses who have had their license lapse for more than one year complete 15 hours of continuing education in nursing or pass the National Council Licensing Examination during the period the Virginia license lapsed in order to have their license reinstated increases costs for these nurses. It will lower their net worth by a few hundred dollars or less. Providers of continuing education may encounter increased business due to this proposal, leading to moderate increases in their revenue and value.

Agency's Response to the Department of Planning and Budget's Economic Impact Analysis: The Board of Nursing generally concurs with the analysis of the Department of Planning and Budget (DPB) for amendments to 18 VAC 90-20 as recommended during a periodic review of regulations.

However, there is one statement that needs to be corrected. The EIA states that the board proposes to require nurses who have had their license lapse for more than one year to complete 15 hours of continuing education or retake the national examination. The regulations allow a nurse to renew a license for up to two years past the renewal date by payment of a late fee along with the renewal fee. Only after two years must a nurse "reinstate" a lapsed license, and the requirement for evidence of continued competency is applicable only to reinstatement. In addition, the requirement would only be applicable to an applicant for reinstatement who does not possess a current, unrestricted license in another jurisdiction and has not been actively practicing.

The EIA made a comment about the requirement for a program director in a practical nursing program to have a baccalaureate degree in nursing, noting that read literally, one who holds a baccalaureate degree in another field but obtained a graduate degree in nursing would not qualify. The board will discuss that observation during the 60-day comment period and consider a revision to accept either degree in nursing.

Summary:

The amendments to existing regulations are proposed pursuant to recommendations from a periodic review to clarify and update certain provisions affecting the nursing education program, the practice of nursing, and medication administration programs. Current regulations for nurse aides and nurse aide education programs found within 18 VAC 90-20 are being repealed and repromulgated in a new set of regulations 18 VAC 90-25, Regulations Governing Certified Nurse Aides. Through its regulatory review, the board determined that a separate set of regulations for nurse aides would be clearer and less cumbersome, especially for nurse aide education programs that have specific criteria for establishing and maintaining an approved program.

Amendments to the nursing and nurse aide education program address concerns about the quality of instruction, the reporting of changes in the program, and other issues related to meeting the educational needs of students. To ease the burden of nursing education programs that undergo extensive review for accreditation by a national nursing credentialing body, it is proposed to allow acceptance of that accreditation for the purpose of continued approval by the board.

Additional requirements are proposed to provide specificity about evidence of continued competency necessary for reinstatement of a license, to provide certain grounds for disciplinary action for the protection of patients or clients, to specify the number of hours of training necessary in a medication administration training program, to update the protocol for adult immunizations, and to state in regulation a policy of the board on the delegation of tasks in an operating room.

18 VAC 90-20-10. Definitions.

The following words and terms when used in this chapter shall have the following meanings; unless the context clearly indicates otherwise:

"Approval" means the process by which the board or a governmental agency in another state or foreign country evaluates and grants official recognition to nursing education programs that meet established standards not inconsistent with Virginia law.

"Associate degree nursing program" means a nursing education program preparing for registered nurse licensure, offered by a Virginia college or other institution and designed to lead to an associate degree in nursing, provided that the institution is authorized to confer such degree by the ~~State Board of Education~~, State Council of Higher Education ~~or an Act of the General Assembly~~.

"Baccalaureate degree nursing program" means a nursing education program preparing for registered nurse licensure, offered by a Virginia college or university and designed to lead to a baccalaureate degree with a major in nursing, provided that the institution is authorized to confer such degree by ~~the State Board of Education~~, the State Council of Higher Education ~~or an Act of the General Assembly~~.

"Board" means the Board of Nursing.

"Clinical nurse specialist" means a licensed registered nurse who holds:

1. A master's degree from a board-approved program which prepares the nurse to provide advanced clinical nursing services; and
2. Specialty certification from a national certifying organization acceptable to the board or an exception available from March 1, 1990, to July 1, 1990.

"Clinical setting" means any location in which the clinical practice of nursing occurs as specified in an agreement between the cooperating agency and the school of nursing.

"Conditional approval" means a time-limited status which results when an approved nursing education program has

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failed to maintain requirements as set forth in Article 2 (~~48 VAC 90-20-10~~ 18 VAC 90-20-70 et seq.) of Part II of this chapter.

"Cooperating agency" means an agency or institution that enters into a written agreement to provide learning experiences for a nursing education program.

"Diploma nursing program" means a nursing education program preparing for registered nurse licensure, offered by a hospital and designed to lead to a diploma in nursing, provided the hospital is licensed in this state.

"NCSBN" means the National Council of State Boards of Nursing.

"National certifying organization" means an organization that has as one of its purposes the certification of a specialty in nursing based on an examination attesting to the knowledge of the nurse for practice in the specialty area *and is accredited by a national body recognized by NCSBN.*

"Nursing education program" means an entity offering a basic course of study preparing persons for licensure as registered nurses or as licensed practical nurses. A basic course of study shall include all courses required for the degree, diploma or certificate.

"Nursing faculty" means registered nurses who teach the practice of nursing in nursing education programs.

"Practical nursing program" means a nursing education program preparing for practical nurse licensure, ~~offered by a Virginia school,~~ that leads to a diploma or certificate in practical nursing, provided the school is authorized by the Virginia State Board of Education or the appropriate governmental credentialing agency.

"Preceptor" means a licensed health care provider who is employed in the clinical setting, serves as a resource person and role model, and is present with the nursing student in that setting.

"Program director" means a registered nurse *who holds a current, unrestricted license in Virginia and* who has been designated by the controlling authority to administer the nursing education program.

"Provisional approval" means the initial status granted to a nursing education program which shall continue until the first class has graduated and the board has taken final action on the application for approval.

"Recommendation" means a guide to actions that will assist an institution to improve and develop its nursing education program.

"Requirement" means a mandatory condition that a nursing education program must meet to be approved.

18 VAC 90-20-35. Identification; accuracy of records.

A. Any person regulated by this chapter who provides direct patient care shall, while on duty, wear identification which clearly indicates the person's *first and last* name and the appropriate title for the license, certification, or registration issued to such person by the board *under which he is practicing in that setting.*

B. A licensee who has changed his name shall submit as legal proof to the board a copy of the marriage certificate or court order evidencing the change. A duplicate license shall be issued by the board upon receipt of such evidence and the required fee.

C. Each licensee shall maintain a record of his current mailing address with the board, and any change of address by a licensee shall be submitted in writing to the board within 30 days of such change. All notices required by law and by this chapter to be mailed by the board to any licensee shall be validly given when mailed to the latest address on file with the board.

18 VAC 90-20-40. Phase-I Application.

A. An institution wishing to establish a nursing education program shall:

1. Submit to the board, at least 12 months in advance of expected opening date, a statement of intent to establish a nursing education program.

2. Submit to the board, ~~along with the statement of intent, evidence documenting adequate resources and the ability to provide a program that can meet the requirements of Article 2 (18 VAC 90-20-70 et seq.) of this part to include~~ the following information:

a. Organizational structure of the institution and relationship of nursing program therein;

b. Purpose and type of program;

c. Availability of qualified faculty;

d. Budgeted faculty positions;

e. Availability of clinical facilities for the program as *evidenced by letters of support indicating a willingness and the ability to provide a clinical site for training;*

f. Availability of academic facilities for the program, *including classrooms, laboratory, and library;*

g. Evidence of financial resources for the planning, implementation and continuation of the program *with budget projections for three years;* and

h. Tentative time schedule for planning and initiating the program.

3. Respond to the board's request for additional information.

B. A site visit may be conducted by a representative of the board.

C. The Education Special Conference Committee (the "committee"), comprised of not less than two members of the board, shall, in accordance with ~~§ 9-6-14:14~~ 2.2-4019 of the Code of Virginia, receive and review applications and the report of the site visit and shall make recommendations to the board regarding the ~~grant~~ *granting* or denial of approval of ~~Phase-I~~ *the program application.*

1. If the board accepts the recommendation to approve ~~Phase-I~~ *the program application,* the institution may apply

for provisional approval of the nursing education program as set forth in this chapter.

2. If the committee recommendation is to deny approval of ~~Phase I~~ *the program application*, no further action will be required of the board unless the program requests a hearing before the board or a panel thereof in accordance with ~~§ 9-6.14:12 2.2-4020~~ and subdivision 9 of § 54.1-2400 of the Code of Virginia.

18 VAC 90-20-50. Phase II Provisional approval.

A. The application for provisional approval shall be complete when the following conditions are met:

1. A program director has been appointed, and there are sufficient faculty to initiate the program *as required in* (18 VAC 90-20-90); and
2. A ~~tentative~~ written curriculum plan developed in accordance with 18 VAC 90-20-120 has been submitted.

B. The committee shall, in accordance with ~~§ 9-6.14:11 2.2-4019~~ of the Code of Virginia, make recommendations to the board for the grant or denial of provisional approval.

1. If provisional approval is granted:
 - a. The admission of students is authorized; and
 - b. The program director shall submit quarterly progress reports to the board which shall include evidence of progress toward application for approval and other information as required by the board.
2. If the committee recommendation is to deny *provisional approval of Phase II*, no further action will be required of the board unless the program requests a hearing before the board or a panel thereof in accordance with ~~§ 9-6.14:12 2.2-4020~~ and subdivision 9 of § 54.1-2400 of the Code of Virginia.

18 VAC 90-20-60. Phase III Program approval.

A. The application for approval shall be complete when:

1. A self-evaluation report of compliance with Article 2 (18 VAC 90-20-70 et seq.) of this part has been submitted;
2. The first graduating class has taken the licensure examination; and
3. A survey visit has been made by a representative of the board.

B. The committee shall, in accordance with ~~§ 9-6.14:11 2.2-4019~~ of the Code of Virginia, receive and review the self-evaluation and survey reports and shall make a recommendation to the board for the ~~grant~~ *granting* or denial of approval *or for continuance of provisional approval*.

C. If the committee's recommendation is to deny approval of ~~Phase III~~, no further action will be required of the board unless the program requests a hearing before the board or a panel thereof in accordance with ~~§ 9-6.14:12 2.2-4020~~ and subdivision 9 of § 54.1-2400 of the Code of Virginia.

18 VAC 90-20-65. Continued approval.

For the purpose of continued approval of a program, the board may accept evidence of accreditation by a nursing education accrediting body recognized by the U.S. Department of Education.

Article 2.
Requirements for *Initial and Continued Approval*.

18 VAC 90-20-90. Faculty.

A. Qualifications.

1. Every member of the nursing faculty, including the program director, shall hold a current, *unrestricted* license to practice as a registered nurse in Virginia. Persons providing instruction in topics other than nursing shall not be required to hold a license as a registered nurse.
2. Every member of a nursing faculty supervising the clinical practice of students shall meet the licensure requirements of the jurisdiction in which that practice occurs.
3. The program director and each member of the nursing faculty shall maintain professional competence through such activities as nursing practice, continuing education programs, conferences, workshops, seminars, academic courses, research projects and professional writing.
4. For baccalaureate degree programs:
 - a. The program director shall hold a doctoral degree *with at least one graduate degree in nursing*.
 - b. Every member of the nursing faculty shall hold *either a graduate degree in nursing or another graduate degree with at least 18 graduate credit hours in nursing*. ~~Faculty members with a graduate degree with a major other than in nursing shall have a baccalaureate degree with a major in nursing.~~
5. For associate degree and diploma programs:
 - a. The program director shall hold a graduate degree, ~~preferably~~ with a major in nursing.
 - b. ~~The majority of the members~~ *Every full-time member of the nursing faculty shall hold either a graduate degree, preferably with a major in nursing or another graduate degree with at least 18 graduate credit hours in nursing.*
 - c. ~~Other~~ *Part-time clinical* members of the nursing faculty shall hold a baccalaureate degree, preferably with a major in nursing.
6. For practical nursing programs:
 - a. The program director shall hold a baccalaureate degree, ~~preferably~~ with a major in nursing.
 - b. The majority of the members of the nursing faculty shall hold a baccalaureate degree, preferably with a major in nursing.
7. Exceptions to provisions of subdivisions 4, 5, and 6 of this subsection ~~shall be by~~ *that do not require board approval*.

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a. Program directors and faculty members employed by an approved educational program on or before [insert effective date of regulations] shall be required to possess the qualifications in effect prior to that date.

b. Faculty who are not licensed nurses may be employed to teach related courses provided they hold a degree that qualifies them to teach the subject matter.

8. Any other exceptions to provisions of subdivisions 4, 5, and 6 of this subsection require board approval as follows:

a. Initial request for exception.

(1) The program director shall submit a request for initial exception in writing ~~for consideration at a regular board meeting~~ prior to the term during which the nursing faculty member is scheduled to teach.

(2) A description of teaching assignment, a curriculum vitae, and a statement of intent from the prospective faculty member to pursue the required degree shall accompany each request.

b. Request for continuing exception.

(1) Continuing exception will be based on the progress of the nursing faculty member toward meeting the degree required by this chapter during each year for which the exception is requested.

(2) The program director shall submit the request for continuing exception in writing ~~for consideration at a regular board meeting~~ prior to the next term during which the nursing faculty member is scheduled to teach.

(3) A list of courses required for the degree being pursued and college transcripts showing successful completion of a minimum of two of the courses during the past academic year shall accompany each request.

c. The executive director of the board shall be authorized to make the initial decision on requests for exceptions. Any appeal of that decision shall be in accordance with the provisions of the Administrative Process Act (§ ~~9-6-14; 2.2-4000~~ et seq. of the Code of Virginia).

B. Number.

1. The number of faculty shall be sufficient to prepare the students to achieve the objectives of the educational program and to ensure safety for patients to whom students provide care.

2. When students are giving direct care to patients, the ratio of students to faculty shall not exceed 10 students to one faculty member.

3. When preceptors are utilized for specified learning experiences in clinical settings, the ratio shall not exceed 15 students to one faculty member.

C. Functions. The principal functions of the faculty shall be to:

1. Develop, implement and evaluate the philosophy and objectives of the nursing education program;

2. Design, implement, teach, evaluate and revise the curriculum;

3. Develop and evaluate student admission, progression, retention and graduation policies within the framework of the controlling institution;

4. Participate in academic advisement and counseling of students;

5. Provide opportunities for student and graduate evaluation of curriculum and teaching and program effectiveness; and

6. Document actions taken in faculty and committee meetings.

18 VAC 90-20-95. Preceptorships.

A. Clinical preceptors may be used to augment the faculty and enhance the clinical learning experience. The clinical preceptor shall be licensed at or above the level for which the student is preparing.

B. When giving direct care to patients, students shall be supervised by faculty or preceptors as designated by faculty. In utilizing preceptors to supervise students, the ratio shall not exceed two students to one preceptor at any given time.

C. Preceptorships shall include:

1. Written objectives, methodology, and evaluation procedures for a specified period of time;

2. An orientation program for faculty, preceptors, and students;

3. The performance of skills for which the student has had *faculty-supervised* clinical and didactic preparation; and

4. The overall coordination by faculty who assume ultimate responsibility for implementation, periodic monitoring, and evaluation.

18 VAC 90-20-120. Curriculum.

A. Curriculum shall reflect the philosophy and objectives of the nursing education program and shall be consistent with the law governing the practice of nursing.

B. Nursing education programs preparing for practical nursing licensure shall include:

1. Principles and practice in nursing encompassing the attainment and maintenance of physical and mental health and the prevention of illness for individuals and groups throughout the life cycle;

2. Basic concepts of the nursing process;

3. Basic concepts of anatomy, physiology, chemistry, ~~physics~~ and microbiology;

4. Basic concepts of communication, growth and development, interpersonal relations, patient education and cultural diversity;

5. Basic concepts of ethics, ~~nursing history and trends~~, and the vocational and legal aspects of nursing, including:

a. Regulations and sections of the Code of Virginia related to nursing;

b. *Patient rights*; and

c. *Prevention of patient abuse, neglect and abandonment*; and

6. Basic concepts of pharmacology, nutrition and diet therapy.

C. Nursing education programs preparing for registered nurse licensure shall include:

1. Theory and practice in nursing, encompassing the attainment and maintenance of physical and mental health and the prevention of illness throughout the life cycle for individuals, groups and communities;

2. Concepts of the nursing process;

3. Concepts of anatomy, physiology, chemistry, and microbiology ~~and physics~~;

4. Sociology, psychology, communications, growth and development, interpersonal relations, group dynamics, cultural diversity and humanities;

5. Concepts of pharmacology, nutrition and diet therapy, and pathophysiology;

6. Concepts of ethics, ~~nursing history and trends~~, and the professional and legal aspects of nursing, including:

a. Regulations and sections of the Code of Virginia related to nursing;

b. *Patient rights*; and

c. *Prevention of patient abuse, neglect and abandonment*.

7. Concepts of leadership, *delegation*, management and patient education.

18 VAC 90-20-140. Program changes.

A. *The following shall be reported to the board within 10 days of the change or receipt of a report from an accrediting body:*

1. *Change in the program director, governing body or parent institution;*

2. *Change in accreditation status; or*

3. *A final report with findings and recommendations from the accrediting body.*

~~Additions, deletions or revisions of courses~~ B. *Curriculum or faculty changes* shall be reported to the board with the annual report required in 18 VAC 90-20-160 A.

18 VAC 90-20-160. Maintaining an approved nursing education program.

A. The program director of each nursing education program shall submit an annual report to the board.

B. Each nursing education program shall be reevaluated as follows:

1. *A program that is not accredited as prescribed in 18 VAC 90-20-65 shall be reevaluated at least every eight years and shall require:* 1. by submission of a comprehensive self-evaluation report based on Article 2 (18 VAC 90-20-70 et

seq.) of this part; and 2. a survey visit by a representative(s) of the board on dates mutually acceptable to the institution and the board.

2. *A program that has maintained accreditation as prescribed in 18 VAC 90-20-65 shall be reevaluated at least every eight years by submission of a comprehensive self-evaluation report as provided by the board. As evidence of compliance with specific requirements of this chapter, the board may accept the most recent report from the accrediting body. If accreditation has been withdrawn or a program has been placed on probation, the board shall conduct an on-site survey visit within one year of such action.*

C. The Education Special Conference Committee (the "committee"), comprised of not less than two members of the board, shall, in accordance with § ~~9-6-14-14~~ 2.2-4019 of the Code of Virginia, receive and review the self-evaluation and survey reports and shall make a recommendation to the board for grant of continued or conditional approval.

1. A nursing education program shall continue to be approved provided the requirements set forth in Article 2 of this part are attained and maintained.

2. If the committee determines that a nursing education program is not maintaining the requirements of Article 2 of this part, the committee shall recommend to the board that the program be placed on conditional approval and the governing institution shall be given a reasonable period of time to correct the identified deficiencies.

a. The committee shall receive and review reports of progress toward correcting identified deficiencies and, when a final report is received at the end of the specified time showing correction of deficiencies, make a recommendation to the board for grant of continued approval.

b. If the governing institution fails to correct the identified deficiencies within the time specified by the committee or an order of the board, the board or a panel thereof may withdraw the approval following a formal hearing.

c. The governing institution may request a formal hearing before the board or a panel thereof pursuant to § ~~9-6-14-12~~ 2.2-4020 and subdivision 9 of § 54.1-2400 of the Code of Virginia if it objects to any action of the board relating to conditional approval.

D. Interim visits shall be made to the institution by board representatives at any time within the eight-year period either by request or as deemed necessary by the board.

18 VAC 90-20-170. Closing of an approved nursing education program; voluntary closing; closing as a result of denial or withdrawal of approval; custody of records.

A. When the governing institution anticipates the closing of a nursing education program, it shall notify the board in writing, stating the reason, plan and date of intended closing.

The governing institution shall assist in the transfer of students to other approved programs with the following conditions:

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1. The program shall continue to meet the standards required for approval until all students are transferred.
 2. A list of the names of students who have been transferred to approved programs and the date on which the last student was transferred shall be submitted to the board by the governing institution.
 3. The date on which the last student was transferred shall be the closing date of the program.
- B. When the board denies or withdraws approval of a program, the governing institution shall comply with the following procedures:
1. The program shall ~~close after the institution has made a reasonable effort to assist in the transfer of students to other approved programs.~~ *be closed according to a time frame for the transfer process shall be established by the board.*
 2. A list of the names of students who have transferred to approved programs and the date on which the last student was transferred shall be submitted to the board by the governing institution.
 3. ~~The date on which the last student was transferred shall be the closing date of the program.~~
- C. Provision shall be made for custody of records as follows:
1. If the governing institution continues to function, it shall assume responsibility for the records of the students and the graduates. The institution shall inform the board of the arrangements made to safeguard the records.
 2. If the governing institution ceases to exist, the academic transcript of each student and graduate shall be transferred by the institution to the board for safekeeping.
- 18 VAC 90-20-190. Licensure by examination.**
- A. The board shall authorize the administration of examinations for registered nurse licensure and examinations for practical nurse licensure.
- B. A candidate shall be eligible to take the examination (i) upon receipt by the board of the completed application, fee and an official transcript from the nursing education program; and (ii) when a determination has been made that no grounds exist upon which the board may deny licensure pursuant to § 54.1-3007 of the Code of Virginia.
- C. To establish eligibility for licensure by examination, an applicant for the licensing examination shall:
1. File the required application, any necessary documentation and fee no later than 60 days prior to the first day of the month in which the applicant expects to take the examination.
 2. Arrange for the board to receive an official transcript from the nursing education program which shows either:
 - a. That the degree or diploma has been awarded; or
 - b. That all requirements for awarding the degree or diploma have been met and specifies the date of conferral.
 3. File a new application and reapplication fee if:
 - a. The examination is not taken within six months of the date that the board determines the applicant to be eligible; or
 - b. Eligibility is not established within six months of the original filing date.
 - D. The minimum passing standard on the examination for registered nurse licensure and practical nurse licensure shall be determined by the board.
 - E. Any applicant suspected of giving or receiving unauthorized assistance during the examination may be noticed for a hearing pursuant to the provisions of the Administrative Process Act (§ ~~9-6-14:1~~ *2.2-4000* et seq. of the Code of Virginia) to determine eligibility for licensure or reexamination.
 - F. The board shall not release examination results of a candidate to any individual or agency without written authorization from the applicant or licensee.
 - G. Practice of nursing pending receipt of examination results.
 1. ~~An eligible~~ *A graduate who has filed an a completed application for licensure in Virginia and has received an authorization letter issued by the board may practice nursing in Virginia for a from the date of the authorization letter. The period of practice shall not to exceed 90 days between the date of successful completion of the nursing education program, as documented on the applicant's transcript, and the receipt publication of the results of the candidate's first licensing examination.*
 2. Candidates who practice nursing as provided in subdivision 1 of this subsection shall use the designation "R.N. Applicant" or "L.P.N. Applicant" on a nametag or when signing official records.
 3. The designations "R.N. Applicant" and "L.P.N. Applicant" shall not be used by applicants who either do not take the examination within 90 days following ~~completion of the nursing education program~~ *receipt of the authorization letter from the board* or who have failed the examination.
 - H. Applicants who fail the examination.
 1. An applicant who fails the licensing examination shall not be licensed or be authorized to practice nursing in Virginia.
 2. An applicant for licensure by reexamination shall file the required application and reapplication fee no later than 60 days prior to the first day of the month in which the applicant expects to take the examination in order to establish eligibility.
 3. Applicants who have failed the examination for licensure in another U.S. jurisdiction but satisfy the qualifications for licensure in this jurisdiction may apply for licensure by examination in Virginia. Such applicants shall submit the required application and fee. Such applicants shall not, however, be permitted to practice nursing in Virginia until the requisite license has been issued.

18 VAC 90-20-200. Licensure by endorsement.

A. A graduate of an approved nursing education program who has been licensed by examination in another U.S. jurisdiction and whose license is in good standing, or is eligible for reinstatement, if lapsed, shall be eligible for licensure by endorsement in Virginia, provided the applicant satisfies the same requirements for registered nurse or practical nurse licensure as those seeking initial licensure in Virginia. A graduate of a nursing school in Canada where English was the primary language shall be eligible for licensure by endorsement provided the applicant has passed the Canadian Registered Nurses Examination (CRNE) and holds an unrestricted license in Canada.

B. An applicant for licensure by endorsement ~~shall submit who has submitted~~ the required application and fee and ~~submit~~ ~~submitted~~ the required form to the appropriate credentialing agency in the state or province of original licensure for verification of licensure ~~may practice for 30 days upon receipt of an authorization letter from the board. Applicants will be notified by the board after 30 days, if the completed verification form has not been received. If an applicant has not received a Virginia license within 30 days and wishes to continue practice, he shall seek an extension of authorization to practice by submitting a request and evidence that he has requested verification of licensure.~~

C. If the application is not completed within one year of the initial filing date, the ~~application shall be retained on file by the board as required for audit~~ applicant shall submit a new application and fee.

18 VAC 90-20-220. Renewal of licenses.

A. Licensees born in even-numbered years shall renew their licenses by the last day of the birth month in even-numbered years. Licensees born in odd-numbered years shall renew their licenses by the last day of the birth month in odd-numbered years.

B. No less than 30 days prior to the last day of the licensee's birth month, an application for renewal of license shall be mailed by the board to the last known address of each licensee, who is currently licensed.

C. The licensee shall complete the application and return it with the required fee.

D. Failure to receive the application for renewal shall not relieve the licensee of the responsibility for renewing the license by the expiration date.

E. The license shall automatically lapse if the licensee fails to renew by the ~~last day of the birth month~~ expiration date.

F. Any person practicing nursing during the time a license has lapsed shall be considered an illegal practitioner and shall be subject to prosecution under the provisions of § 54.1-3008 of the Code of Virginia.

18 VAC 90-20-230. Reinstatement of lapsed licenses.

A. A nurse whose license has lapsed may be reinstated within one renewal period by payment of the current renewal fee and the late renewal fee.

B. A nurse whose license has lapsed for more than one renewal period shall:

1. File a reinstatement application and pay the reinstatement fee; and
2. Provide evidence of completing 15 hours of continuing education in nursing approved by a regionally accredited educational institution or professional nursing organization or of passage of National Council Licensing Examination during the period in which the license has been lapsed.

C. The board may waive all or part of the continuing education requirement for a nurse who holds a current, unrestricted license in another state and who has engaged in active practice during the period the Virginia license was lapsed.

~~C. D.~~ A nurse whose license has been suspended or revoked by the board may apply for reinstatement by filing a reinstatement application, fulfilling requirements for continuing competency as required in subsection B of this section and paying the fee for reinstatement after suspension or revocation. A nurse whose license has been revoked may not apply for reinstatement sooner than two years from entry of the order of revocation.

~~D. E.~~ The board may request additional evidence that the nurse is prepared to resume practice in a competent manner.

18 VAC 90-20-270. Supervision of licensed practical nurses.

Licensed practical nursing is performed under the direction or supervision of a licensed medical practitioner, a registered nurse or a licensed dentist within the context of § 54.1-3408 of the Code of Virginia.

18 VAC 90-20-280. Clinical nurse specialist registration.

A. Initial registration. An applicant for initial registration as a clinical nurse specialist shall:

1. Be currently licensed as a registered nurse in Virginia;
2. Submit evidence of graduation from an approved program as defined in 18 VAC 90-20-275;
3. Submit evidence of current specialty certification from a national certifying organization as defined in 18 VAC 90-20-10; and
4. Submit the required application and fee.

B. Renewal of registration.

1. Registration as a clinical nurse specialist shall be renewed biennially at the same time the registered nurse license is renewed.
2. The clinical nurse specialist shall complete the renewal application and return it with the required fee and evidence of current specialty certification unless registered in accordance with an exception.
3. Registration as a clinical nurse specialist shall lapse if the registered nurse license is not renewed and may be reinstated as follows upon:
 - a. Reinstatement of R.N. license;

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- b. Payment of reinstatement and current renewal fees; and
- c. Submission of evidence of continued specialty certification unless registered in accordance with an exception.

18 VAC 90-20-300. Disciplinary provisions.

A. The board has the authority to deny, revoke or suspend a license issued, or to otherwise discipline a licensee, upon proof that the licensee has violated any of the provisions of § 54.1-3007 of the Code of Virginia. For the purpose of establishing allegations to be included in the notice of hearing, the board has adopted the following definitions:

1. Fraud or deceit *in procuring or maintaining a license* means, but shall not be limited to:
 - a. Filing false credentials;
 - b. Falsely representing facts on an application for initial license, reinstatement or renewal of a license; or
 - c. Giving or receiving assistance in the taking of the licensing examination.
2. Unprofessional conduct means, but shall not be limited to:
 - a. Performing acts beyond the limits of the practice of professional or practical nursing as defined in Chapter 30 (§ 54.1-3000 et seq.) of Title 54.1 of the Code of Virginia, or as provided by §§ 54.1-2901 and 54.1-2957 of the Code of Virginia;
 - b. Assuming duties and responsibilities within the practice of nursing without adequate training or when competency has not been maintained;
 - c. Obtaining supplies, equipment or drugs for personal or other unauthorized use;
 - d. Employing or assigning unqualified persons to perform functions that require a licensed practitioner of nursing;
 - e. Falsifying or otherwise altering patient or , employer, student, or educational program records, including falsely representing facts on a job application or other employment-related documents;
 - f. Abusing, neglecting or abandoning patients or clients;
 - g. Practice of a clinical nurse specialist beyond that defined in 18 VAC 90-20-290;
 - h. Representing oneself as or performing acts constituting the practice of a clinical nurse specialist unless so registered by the board; or
 - i. Delegating nursing tasks to an unlicensed person in violation of the provisions of Part X VIII (18 VAC 90-20-420 et seq.) of this chapter.;
 - j. Giving to or accepting from a patient or client property or money for any reason other than fee for service or a nominal token of appreciation;
 - k. Obtaining money or property of a patient or client by fraud, misrepresentation or duress;

l. Entering into a relationship with a patient or client that constitutes a professional boundary violation in which the nurse uses his professional position to take advantage of a client's vulnerability, to include but not limited to actions that result in personal gain at the expense of the patient, a nontherapeutic personal involvement or sexual conduct with a patient; or

m. Violating state or federal laws relating to the privacy of patient information, including but not limited to § 32.1-127.1:03 of the Code of Virginia.

B. Any sanction imposed on the registered nurse license of a clinical nurse specialist shall have the same effect on the clinical nurse specialist registration.

PART VI. CERTIFIED NURSE AIDES.

18 VAC 90-20-310. Definitions (Repealed).

~~The following words and terms when used in this chapter shall have the following meanings, unless the context clearly indicates otherwise:~~

~~"Nurse aide education program" means a program designed to prepare nurse aides for certification.~~

~~"Nursing facility" means a licensed nursing home or an entity which is certified for Medicare or Medicaid long term care reimbursement.~~

~~"Primary instructor" means a registered nurse who is responsible for teaching and evaluating the students enrolled in a nurse aide education program.~~

~~"Program coordinator" means a registered nurse who is administratively responsible and accountable for a nurse aide education program.~~

~~"Program provider" means an entity which conducts a nurse aide education program.~~

18 VAC 90-20-320. Delegation of authority (Repealed).

~~The executive director of the board shall issue a certificate as a certified nurse aide to each applicant who qualifies for such a certificate under §§ 54.1-3024, 54.1-3025, 54.1-3026 and 54.1-3028 of the Code of Virginia.~~

18 VAC 90-20-330. Nurse aide education programs (Repealed).

~~A. Establishing a nurse aide education program.~~

~~1. A program provider wishing to establish a nurse aide education program shall submit an application to the board at least 90 days in advance of the expected opening date.~~

~~2. The application shall provide evidence of the ability of the institution to comply with subsection B of this section.~~

~~3. The Education Special Conference Committee (the "committee"), comprised of not less than two members of the board, shall, in accordance with § 9-6.14:11 of the Code of Virginia, receive and review the application and shall make a recommendation to the board for grant or denial of approval.~~

4. If the committee's recommendation is to deny approval, no further action will be required of the board unless the program requests a hearing before the board or a panel thereof in accordance with § 9-6.14:12 and subdivision 11 of § 54.1-2400 of the Code of Virginia.

B. ~~Maintaining an approved nurse aide education program. To maintain approval, the nurse aide education program shall:~~

1. ~~Demonstrate evidence of compliance with the following essential elements:~~

a. ~~Curriculum content and length as set forth in subsections D and G of this section.~~

b. ~~Maintenance of qualified instructional personnel as set forth in subsection C of this section.~~

c. ~~Classroom facilities that meet requirements set forth in subsection H of this section.~~

d. ~~Maintenance of records as set forth in subsection E of this section.~~

e. ~~Skills training experience in a nursing facility which has not been subject to penalty or penalties as provided in 42 CFR 483.151(b)(2) (Medicare and Medicaid Programs: Nurse Aide Training and Competency Evaluation Programs, effective April 1, 1992) in the past two years. The foregoing shall not apply to a nursing facility which has received a waiver from the state survey agency in accordance with federal law.~~

f. ~~Agreement that board representatives may make unannounced visits to the program.~~

g. ~~Financial support and resources sufficient to meet requirements of this chapter.~~

2. ~~Impose no fee for any portion of the program on any nurse aide who, on the date on which the nurse aide begins the program, is either employed or has an offer of employment from a nursing facility.~~

3. ~~Provide each student applying to or enrolled in such program with a copy of applicable Virginia law regarding criminal history records checks for employment in certain health care facilities, and a list of crimes which pose a barrier to such employment.~~

4. ~~Report all substantive changes in subdivision 1 of this subsection within 10 days of the change to the board.~~

C. ~~Instructional personnel.~~

1. ~~Program coordinator.~~

a. ~~The program coordinator in a nursing facility based program may be the director of nursing services. The director of nursing may assume the administrative responsibility and accountability for the nurse aide education program but shall not engage in the actual classroom and clinical teaching.~~

b. ~~The primary instructor may be the program coordinator in any nurse aide education program.~~

2. ~~Primary instructor.~~

a. ~~Qualifications. The primary instructor, who does the actual teaching of the students:~~

(1) ~~Shall hold a current Virginia license as a registered nurse; and~~

(2) ~~Shall have two years of experience as a registered nurse within the previous five years and at least one year of experience in the provision of long-term care facility services. Such experience may include, but not be limited to, employment in a nurse aide education program or employment in or supervision of nursing students in a nursing facility or unit, geriatrics department, chronic care hospital, home care or other long-term care setting. Experience should include varied responsibilities, such as direct resident care, supervision and education.~~

b. ~~Responsibilities. The primary instructor shall participate in the teaching and evaluation of students and, in addition, shall:~~

(1) ~~Participate in the planning of each learning experience;~~

(2) ~~Ensure that course objectives are accomplished;~~

(3) ~~Ensure that the provisions of subdivision 6 of this subsection are maintained;~~

(4) ~~Maintain records as required by subsection E of this section;~~

(5) ~~Perform other activities necessary to comply with subsection B of this section; and~~

(6) ~~Ensure that students do not perform services for which they have not received instruction and been found proficient by the instructor.~~

3. ~~Other instructional personnel.~~

a. ~~Qualifications.~~

(1) ~~A registered nurse shall:~~

(a) ~~Hold a current Virginia license as a registered nurse; and~~

(b) ~~Have had at least one year of direct patient care experience as a registered nurse.~~

(2) ~~A licensed practical nurse shall:~~

(a) ~~Hold a current Virginia license as a practical nurse;~~

(b) ~~Hold a high school diploma or equivalent;~~

(c) ~~Have been graduated from a state approved practical nursing program; and~~

(d) ~~Have had at least two years of direct patient care experience as a licensed practical nurse.~~

b. ~~Responsibilities. Other personnel shall provide instruction under the general supervision of the primary instructor.~~

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4. ~~Prior to being assigned to teach the nurse aide education program, all instructional personnel shall demonstrate competence to teach adults by one of the following:~~

~~a. Complete satisfactorily a course in teaching adults that includes:~~

- ~~(1) Basic principles of adult learning;~~
- ~~(2) Teaching methods and tools for adult learners; and~~
- ~~(3) Evaluation strategies and measurement tools for assessing the learning outcomes;~~

~~b. Have experience in teaching adults; or~~

~~c. Have experience in supervising nurse aides.~~

5. ~~The program may utilize resource personnel who have had at least one year of experience in their field to meet the planned program objectives for specific topics.~~

6. ~~When students are giving direct care to clients in clinical areas, instructional personnel must be on site solely to supervise the students. The ratio of students to each instructor shall not exceed 10 students to one instructor.~~

D. Curriculum content.

1. ~~The curriculum shall include, but shall not be limited to, classroom and clinical instruction in the following:~~

~~a. Initial core curriculum. Prior to the direct contact of a student with a nursing facility client, a total of at least 16 hours of instruction in the following areas must be presented:~~

- ~~(1) Communication and interpersonal skills;~~
- ~~(2) Infection control;~~
- ~~(3) Safety and emergency procedures, including the Heimlich Maneuver;~~
- ~~(4) Promoting client independence; and~~
- ~~(5) Respecting clients' rights.~~

~~b. Basic skills.~~

- ~~(1) Recognizing changes in body functioning and the importance of reporting such changes to a supervisor.~~
- ~~(2) Measuring and recording routine vital signs.~~
- ~~(3) Measuring and recording height and weight.~~
- ~~(4) Caring for the clients' environment.~~
- ~~(5) Measuring and recording fluid and food intake and output.~~
- ~~(6) Performing basic emergency measures.~~
- ~~(7) Caring for a client when death is imminent.~~

~~c. Personal care skills.~~

- ~~(1) Bathing and oral hygiene.~~
- ~~(2) Grooming.~~
- ~~(3) Dressing.~~

~~(4) Toileting.~~

~~(5) Assisting with eating and hydration, including proper feeding techniques.~~

~~(6) Caring for skin, to include prevention of pressure ulcers.~~

~~(7) Transfer, positioning and turning.~~

~~d. Individual client's needs, including mental health and social service needs.~~

~~(1) Modifying the aide's behavior in response to the behavior of clients.~~

~~(2) Identifying developmental tasks associated with the aging process.~~

~~(3) Demonstrating principles of behavior management by reinforcing appropriate behavior and causing inappropriate behavior to be reduced or eliminated.~~

~~(4) Demonstrating skills supporting age appropriate behavior by allowing the client to make personal choices, and by providing and reinforcing other behavior consistent with the client's dignity.~~

~~(5) Utilizing the client's family or concerned others as a source of emotional support.~~

~~(6) Responding appropriately to the client's behavior.~~

~~(7) Providing appropriate clinical care to the aged and disabled.~~

~~(8) Providing culturally sensitive care.~~

~~e. Care of the cognitively impaired client.~~

~~(1) Using techniques for addressing the unique needs and behaviors of individuals with dementia (Alzheimer's and others).~~

~~(2) Communicating with cognitively impaired residents.~~

~~(3) Demonstrating and understanding the behavior of cognitively impaired residents.~~

~~(4) Responding appropriately to the behavior of cognitively impaired residents.~~

~~(5) Using methods to reduce the effects of cognitive impairment.~~

~~f. Skills for basic restorative services.~~

~~(1) Using assistive devices in transferring, ambulation, eating and dressing.~~

~~(2) Maintaining range of motion.~~

~~(3) Turning and positioning, both in bed and chair.~~

~~(4) Bowel and bladder training.~~

~~(5) Caring for and using prosthetic and orthotic devices.~~

~~(6) Teaching the client in self-care according to the client's abilities as directed by a supervisor.~~

~~g. Clients' rights.~~

- ~~(1) Providing privacy and maintaining confidentiality.~~
- ~~(2) Promoting the client's right to make personal choices to accommodate individual needs.~~
- ~~(3) Giving assistance in resolving grievances and disputes.~~
- ~~(4) Providing assistance necessary to participate in client and family groups and other activities.~~
- ~~(5) Maintaining care and security of the client's personal possessions.~~
- ~~(6) Promoting the resident's rights to be free from abuse, mistreatment and neglect and the need to report any instances of such treatment to appropriate staff.~~
- ~~(7) Avoiding the need for restraints in accordance with current professional standards.~~

~~h. Legal aspects of practice as a certified nurse aide.~~

~~i. Occupational health and safety measures.~~

~~j. Appropriate management of conflict.~~

~~2. Unit objectives.~~

~~a. Objectives for each unit of instruction shall be stated in behavioral terms which are measurable.~~

~~b. Objectives shall be reviewed with the students at the beginning of each unit.~~

~~E. Records.~~

~~1. Each nurse aide education program shall develop an individual record of major skills taught and the date of performance by the student. At the completion of the nurse aide education program, the nurse aide must receive a copy of this record.~~

~~2. A record of the reports of graduates' performance on the approved competency evaluation program shall be maintained.~~

~~3. A record that documents the disposition of complaints against the program shall be maintained.~~

~~F. Student identification. The nurse aide students shall wear identification that clearly distinguishes them as students to clients, visitors and staff.~~

~~G. Length of program.~~

~~1. The program shall be at least 120 clock hours in length.~~

~~2. The program shall provide for at least 16 hours of instruction prior to direct contact of a student with a nursing facility client.~~

~~3. Skills training in clinical settings shall be at least 40 hours. Five of the clinical hours may be in a setting other than a nursing home.~~

~~4. Employment orientation to facilities used in the education program must not be included in the 120 hours allotted for the program.~~

~~H. Classroom facilities. The nurse aide education program shall provide facilities that meet federal and state requirements including:~~

~~1. Comfortable temperatures.~~

~~2. Clean and safe conditions.~~

~~3. Adequate lighting.~~

~~4. Adequate space to accommodate all students.~~

~~5. All equipment needed, including audio visual equipment and that needed for simulating resident care.~~

~~I. Program review.~~

~~1. Each nurse aide education program shall be reviewed on site by an agent of the board at least every two years following initial review.~~

~~2. The committee, in accordance with § 9-6.14:11 of the Code of Virginia, shall receive and review the report of the site visit and shall make recommendations to the board to grant or deny continued approval.~~

~~a. A nurse aide education program shall continue to be approved provided the requirements set forth in subsections B through H of this section are maintained.~~

~~b. If the committee determines that a nurse aide education program is not maintaining the requirements of subsections B through H of this section, with the exception of subdivision B 1 e of this section, the committee shall recommend to the board that the program be placed on conditional approval and the program provider shall be given a reasonable period of time to correct the identified deficiencies.~~

~~(1) The committee shall receive and review reports of progress toward correcting identified deficiencies and, when a final report is received at the end of the specified time showing corrections of deficiencies, make a recommendation to the board for grant of continued approval.~~

~~(2) If the program provider fails to correct the identified deficiencies within the time specified by the committee or the board, the board or a panel thereof may withdraw approval following a hearing in accordance with § 9-6.14:12 and subdivision 11 of § 54.1-2400 of the Code of Virginia.~~

~~(3) The program provider may request a formal hearing before the board or a panel thereof pursuant to § 9-6.14:12 and subdivision 11 of § 54.1-2400 of the Code of Virginia if it objects to any action of the board relating to conditional approval.~~

~~3. The program coordinator shall prepare and submit a program evaluation report on a form provided by the board in the intervening year that an on site review is not conducted.~~

~~J. Curriculum changes. Changes in curriculum shall be approved by the board prior to implementation and shall be submitted at the time of the site visit or with the report submitted by the program coordinator in the intervening year.~~

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K. Interruption of program.

~~1. When a program provider does not wish to admit students for a period not to exceed one year, the provider may request that the program be placed on inactive status and shall not be subject to compliance with subsection B of this section for the specified time.~~

~~2. Unless the program provider notifies the board that it intends to admit students, the program will be considered closed at the end of the one-year period and be subject to the requirements of subsection L of this section.~~

~~3. If the program provider does not offer the program for two consecutive years, the program shall be considered closed and shall be subject to the requirements of subsection L of this section.~~

L. Closing of a nurse aide education program. When a nurse aide education program closes, the program provider shall:

~~1. Notify the board of the date of closing.~~

~~2. Submit to the board a list of all graduates with the date of graduation of each.~~

18 VAC 90-20-340. Nurse aide competency evaluation (Repealed).

~~A. The board may contract with a test service for the development and administration of a competency evaluation.~~

~~B. All individuals completing a nurse aide education program in Virginia shall successfully complete the competency evaluation required by the board prior to making application for certification and to using the title Certified Nurse Aide.~~

~~C. The board shall determine the minimum passing standard on the competency evaluation.~~

18 VAC 90-20-350. Nurse aide registry (Repealed).

A. Initial certification by examination.

~~1. To be placed on the registry and certified, the nurse aide must:~~

~~a. Satisfactorily complete a nurse aide education program approved by the board; or~~

~~b. Be enrolled in a nursing education program preparing for registered nurse or practical nurse licensure, have completed at least one nursing course which includes clinical experience involving client care; or~~

~~c. Have completed a nursing education program preparing for registered nurse licensure or practical nurse licensure; and~~

~~d. Pass the competency evaluation required by the board; and~~

~~e. Submit the required application and fee to the board.~~

~~2. Initial certification by endorsement.~~

~~a. A graduate of a state approved nurse aide education program who has satisfactorily completed a competency evaluation program and is currently registered in another~~

~~state may apply for certification in Virginia by endorsement.~~

~~b. An applicant for certification by endorsement shall submit the required application and fee and submit the required verification form to the credentialing agency in the state where registered, certified or licensed within the last two years.~~

~~3. Initial certification shall be for two years.~~

B. Renewal of certification.

~~1. No less than 30 days prior to the expiration date of the current certification, an application for renewal shall be mailed by the board to the last known address of each currently registered certified nurse aide.~~

~~2. The certified nurse aide shall return the completed application with the required fee of \$45 and verification of performance of nursing related activities for compensation within the preceding two years. The board shall also charge a fee of \$25 for a returned check.~~

~~3. Failure to receive the application for renewal shall not relieve the certificate holder of the responsibility for renewing the certification by the expiration date.~~

~~4. A certified nurse aide who has not performed nursing related activities for compensation during the two years preceding the expiration date of the certification shall repeat and pass the nurse aide competency evaluation prior to applying for recertification.~~

C. Reinstatement of lapsed certification. An individual whose certification has lapsed shall file the required application and renewal fee and:

~~1. Verification of performance of nursing related activities for compensation prior to the expiration date of the certificate and within the preceding two years; or~~

~~2. When nursing activities have not been performed during the preceding two years, evidence of having repeated and passed the nurse aide competency evaluation.~~

~~D. Evidence of change of name. A certificate holder who has changed his name shall submit as legal proof to the board a copy of the marriage certificate or court order authorizing the change. A duplicate certificate shall be issued by the board upon receipt of such evidence and the required fee.~~

E. Requirements for current mailing address.

~~1. All notices required by law and by this chapter to be mailed by the board to any certificate holder shall be validly given when mailed to the latest address on file with the board.~~

~~2. Each certificate holder shall maintain a record of his current mailing address with the board.~~

~~3. Any change of address by a certificate holder shall be submitted in writing to the board within 30 days of such change.~~

18 VAC 90-20-360. Denial, revocation or suspension (Repealed).

~~The board has the authority to deny, revoke or suspend a certificate issued, or to otherwise discipline a certificate holder upon proof that he has violated any of the provisions of § 54.1-3007 of the Code of Virginia. For the purpose of establishing allegations to be included in the notice of hearing, the board has adopted the following definitions:~~

- ~~1. Fraud or deceit shall mean, but shall not be limited to:

 - a. Filing false credentials;
 - b. Falsely representing facts on an application for initial certification, reinstatement or renewal of a certificate; or
 - c. Giving or receiving assistance in taking the competency evaluation.~~
- ~~2. Unprofessional conduct shall mean, but shall not be limited to:

 - a. Performing acts beyond those authorized for practice as a nurse aide or an advanced certified nurse aide as defined in Chapter 30 (§ 54.1-3000 et seq.) of Title 54.1 of the Code of Virginia;
 - b. Assuming duties and responsibilities within the practice of a nurse aide or an advanced certified nurse aide without adequate training or when competency has not been maintained;
 - c. Obtaining supplies, equipment or drugs for personal or other unauthorized use;
 - d. Falsifying or otherwise altering client or employer records;
 - e. Abusing, neglecting or abandoning clients; or
 - f. Having been denied a license or having had a license issued by the board revoked or suspended.~~

PART ~~VI~~ VI.

MEDICATION ADMINISTRATION TRAINING PROGRAM.

18 VAC 90-20-390. Content.

The curriculum shall include a *minimum of 24 hours* of classroom instruction and practice in the following:

1. Preparing for safe administration of medications to clients in specific settings by:
 - a. Demonstrating an understanding of the client's rights regarding medications, treatment decisions and confidentiality.
 - b. Recognizing emergencies and other health-threatening conditions and responding accordingly.
 - c. Identifying medication terminology and abbreviations.
2. Maintaining aseptic conditions by:
 - a. Implementing universal precautions.
 - b. Insuring cleanliness and disinfection.
 - c. Disposing of infectious or hazardous waste.

3. Facilitating client self-administration or assisting with medication administration by:

- a. Reviewing administration records and prescriber's orders.
 - b. Facilitating client's awareness of the purpose and effects of medication.
 - c. Assisting the client to interpret prescription labels.
 - d. Observing the five rights of medication administration and security requirements appropriate to the setting.
 - e. Following proper procedure for preparing medications.
 - f. Measuring and recording vital signs to assist the client in making medication administration decisions.
 - g. Assisting the client to administer oral medications.
 - h. Assisting the client with administration of prepared instillations and treatments of:
 - (1) Eye drops and ointments.
 - (2) Ear drops.
 - (3) Nasal drops and sprays.
 - (4) Topical preparations.
 - (5) Compresses and dressings.
 - (6) Vaginal and rectal products.
 - (7) Soaks and sitz baths.
 - (8) Inhalation therapy.
 - (9) Oral hygiene products.
 - i. Reporting and recording the client's refusal to take medication.
 - j. Documenting medication administration.
 - k. Documenting and reporting medication errors.
 - l. Maintaining client records according to facility policy.
 - m. Sharing information with other staff orally and by using documents.
 - n. Storing and securing medications.
 - o. Maintaining an inventory of medications.
 - p. Disposing of medications.
4. Facilitating client self-administration or assisting with the administration of insulin. Instruction and practice in the administration of insulin shall be included only in those settings where required by client needs and shall include:
- a. Cause and treatment of diabetes.
 - b. The side effects of insulin.
 - c. Preparation and administration of insulin.

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PART ~~VIII~~ VII.
PROTOCOL FOR ADULT IMMUNIZATION.

18 VAC 90-20-410. Requirements for protocol for administration of adult immunization.

Pursuant to provisions of § 54.1-3408 of the Code of Virginia, a protocol shall be submitted to the board prior to the administration of an adult immunization program which includes the following:

1. Purpose and objectives of immunization program.
2. Target population.
3. Name and address of medical director.
4. A signed and dated medical directive.
5. Screening criteria for inclusion and exclusion.
6. Informed consent form.
7. Immunization procedures.
 - a. Dosage.
 - b. Single or multiple dose administration.
 - c. Injection site.
 - d. Vaccine storage.
 - e. Biohazardous waste disposal.
 - f. ~~Universal~~ *Standard* precautions.
8. Post-immunization instructions.
9. Emergency guidelines.
10. Qualification of immunization providers.
 - a. Virginia licensure as a registered nurse, licensed practical nurse, or pharmacist.
 - b. Supervision of LPN provider.
 - c. *Current cardiopulmonary resuscitation training.*
11. Resource personnel and supervision.
12. Sample of patient record with date, vaccine, dose, site, expiration date, lot number, and administering person's signature.

PART ~~VIII~~ VIII.
DELEGATION OF NURSING TASKS AND PROCEDURES.

18 VAC 90-20-460. Nursing tasks that shall not be delegated.

A. Nursing tasks that shall not be delegated are those which are inappropriate for a specific, unlicensed person to perform on a specific patient after an assessment is conducted as provided in 18 VAC 90-20-440.

B. Nursing tasks that shall not be delegated to any unlicensed person are:

1. Activities involving nursing assessment, problem identification, and outcome evaluation which require independent nursing judgment;

2. Counseling or teaching except for activities related to promoting independence in personal care and daily living;
3. Coordination and management of care involving collaboration, consultation and referral;
4. Emergency and nonemergency triage; ~~and~~
5. Administration of medications except as specifically permitted by the Virginia Drug Control Act (§ 54.1-3400 et seq. of the Code of Virginia); *and*
6. *Circulating duties in an operating room.*

<p>NOTICE: The forms used in administering 18 VAC 90-20, Regulations Governing the Practice of Nursing, are not being published due to the large number; however, the name of each form is listed below. The forms are available for public inspection at the Department of Health Professions, Board of Nursing, 6603 W. Broad Street, Richmond, Virginia, or at the office of the Registrar of Regulations, General Assembly Building, 2nd Floor, Richmond, Virginia.</p>
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FORMS

Application for Licensure by Endorsement -Registered Nurse (rev. 10/02).

Instructions for Licensure by Endorsement -Registered Nurse (rev. 10/02).

Instructions for Licensure by Endorsement -Licensed Practical Nurse (rev. 10/02).

Application for Licensure by Endorsement -icensed Practical Nurse (rev. 10/02).

Instructions for Filing Application for Licensure by Examination for Registered Nurses, RN1-INS (rev. 10/02).

Application for Licensure by Examination -Registered Nurse (rev. 10/02).

Instructions for Filing Application for Licensure by Examination for Practical Nurses, PN1-INS (rev. 10/02).

Application for Licensure by Examination -Licensed Practical Nurse (rev. 10/02).

Instructions for Filing Application for Licensure by Repeat Examination for Registered Nurses, RN2-INS (rev. 10/02).

Application for Licensure by Repeat Examination for Registered Nurse (rev. 10/02).

Instructions for Filing Application for Licensure by Repeat Examination for Practical Nurses, PN2-INS (rev. 10/02).

Application for Licensure by Repeat Examination for Licensed Practical Nurse (rev. 10/02).

Instructions for Filing Application for Licensure by Examination for Licensed Practical Nurses Educated in Other Countries, PNF-INS (rev. 10/02).

Application for Licensure by Examination for Registered Nurses Educated in Other Countries (rev. 10/02).

Temporary Exemption To Licensure (eff. 10/02).

Application for Licensure by Examination for Licensed Practical Nurses Educated in Other Countries (rev. 10/02).

Application for Reinstatement of License as a Registered Nurse (rev. 10/02).

Application for Reinstatement of License as a Licensed Practical Nurse (rev. 10/02).

License Verification Form (rev. 10/02).

Renewal Notice and Application, 0001, RN (rev. 12/02).

Renewal Notice and Application, 0002, LPN (rev. 12/02).

Renewal Notice and Application, 0015, Clinical Nurse Specialist (rev. 12/02).

Application for Registration as a Clinical Nurse Specialist (rev. 10/02).

Survey Visit Report (rev. 12/02).

Annual Report for Registered Nursing Programs (rev. 12/02).

Annual Report for Practical Nursing Programs (rev. 12/02).

~~Renewal Notice and Application 1401, Certified Nurse Aide (rev. 12/02).~~

~~Renewal Notice and Application, Advanced Certified Nurse Aide (eff. 12/02).~~

~~Instructions for Application for Certification as Advanced Certified Nurse Aide (eff. 2/03).~~

~~Application for Certification as Advanced Certified Nurse Aide (eff. 2/03).~~

~~Application for Reinstatement of Nurse Aide Certification (rev. 12/02).~~

~~Instructions for Application for Reinstatement of Nurse Aide Certification (rev. 12/02).~~

~~Instructions for Application for Reinstatement of Advanced Nurse Aide Certification (eff. 2/03).~~

~~Application for Reinstatement of Advanced Nurse Aide Certification (eff. 2/03).~~

~~Application for Nurse Aide Certification by Endorsement (rev. 12/02).~~

~~Instructions for Application for Nurse Aide Certification by Endorsement (rev. 12/02).~~

~~Nurse Aide Certification Verification Form (rev. 12/02).~~

~~Application to Establish a Nurse Aide Education Program (rev. 12/02).~~

~~Application to Establish an Advanced Certification Nurse Aide Education Program (eff. 12/02).~~

~~Nurse Aide Education Program Program Evaluation Report (rev. 11/02).~~

~~Nurse Aide Education Program On-Site Review Report (rev. 12/02).~~

~~Advanced Certification Nurse Aide Education Program On-site Review Report (eff. 12/02).~~

~~Evaluation of On-Site Visitor (eff. 12/02).~~

~~Request for Statistical Information (eff. 12/02).~~

Application for Registration for Volunteer Practice (eff. 12/02).

Sponsor Certification for Volunteer Registration (eff. 1/03).

VA.R. Doc. No. R02-143A; Filed December 9, 2003, 2:48 p.m.

Title of Regulation: 18 VAC 90-25. Regulations Governing Certified Nurse Aides (adding 18 VAC 90-25-10 through 18 VAC 90-25-100).

Statutory Authority: § 54.1-2400 and Article 4 (§ 54.1-3022 et seq.) of Chapter 30 of Title 54.1 of the Code of Virginia.

Public Hearing Date: January 27, 2004 - 11 a.m.

Public comments may be submitted until February 27, 2004. (See Calendar of Events section for additional information)

Agency Contact: Elaine J. Yeatts, Agency Regulatory Coordinator, Department of Health Professions, 6603 West Broad Street, Richmond, VA 23230, telephone (804) 662-9918, FAX (804) 662-9114, or e-mail elaine.yeatts@dhp.state.va.us.

Basis: Section 54.1-2400 of the Code of Virginia establishes the general powers and duties of health regulatory boards including the responsibility to promulgate regulations, levy fees, administer a licensure and renewal program, and discipline regulated professionals.

Statutes governing the approval of nurse aide education and the certification of nurse aides are found in Article 4 (§ 54.1-3022 et seq.) of Chapter 30 of Title 54.1 of the Code of Virginia.

Purpose: Regulations for nurse aide education programs and certification of nurse aides have been incorporated into the Regulations Governing the Practice of Nursing. While there have been no specific problems with the inclusion of rules for nurse aides in with rules for nurses, the board felt that it was appropriate and advisable to separate the requirements into two distinct regulations. In addition, the nurse aide education program regulations have been stated in one section that has become quite lengthy and cumbersome. Reorganization of those requirements will make them clearer and more precise. Regulations for advanced certification of nurse aides have also been proposed in another action and will be incorporated into these regulations.

The purpose of the amendments resulting from regulatory review is to make the rules more explicit in certain areas where there has been confusion or lack of clarity and to clearly state board policy in regulation. The process and expectations of the board in granting initial or continued approval of a nurse aide education program are more explicitly stated to better protect students who are enrolled or applying for enrollment. Using its disciplinary cases as guidance, the board identified several areas in nurse aide education where additional training or emphasis was needed. It also added some grounds for disciplinary action to strengthen the ability of the board to discipline a nurse aide

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who has violated a patient in some manner. Increasing the knowledge and skills of nurse aides in dealing with an elderly population may improve the quality of care patients receive. Having a clearer understanding of ethical practice may prevent some cases of patient abuse or neglect. Amendments to the program requirements and the reinstatement and disciplinary provisions are proposed to ensure greater protection and improve the quality of care for a frail, very vulnerable population in the Commonwealth.

Substance: To ensure that nurse aide education programs are providing students with the training necessary to work in a long-term care environment with elderly patients, amendments are proposed to specify certain requirements for maintaining board approval, to clarify that the instructors must be licensed nurses, and to specify an additional eight hours in the core curriculum to include instruction in fall prevention, dealing with aggressive patients, communicating with sensory-impaired patients, and in the rules governing practice. Amendments also state the board policy for reinstatement of an expired certification, including the prohibition on reinstatement if there has been a finding against a nurse aide. The ability of the board to take disciplinary action is strengthened by adding provisions related to violating the rights or property of a patient and by an interpretation of the law on restricting the certification of a nurse aide.

Issues:

Advantages or disadvantages to the public. Since nurse aides provide the direct patient care to patients in nursing homes or other long-term care facilities, any additional training or knowledge of appropriate responses to those patients is advantageous. While the proposed regulations do not increase the total number of hours of nurse aide education, the amendments will require that an additional eight hours in the core curriculum and training in crucial areas such as fall prevention and communicating with impaired patients. Learning how to respond appropriately to aggressive patients may prevent some cases of patient abuse and better protect both the patient and the aide. Likewise, a clearer understanding of the consequences of unethical behavior may be beneficial to the nurse aides and their patients. If disciplinary action is warranted, the additional grounds for such action will ensure that an aide who has violated the rights or property of a patient is appropriately disciplined by the board. There are no disadvantages to the public, which is better protected by more clearly stated, explicit requirements for the training and practice of nurse aides.

Advantages or disadvantages to the agency. There are no specific advantages or disadvantages to the agency. There may be better compliance with board rules and policies as a result of more clearly stated regulations. There should be no additional cost associated with the licensure or enforcement activities of the board.

Department of Planning and Budget's Economic Impact Analysis: The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with § 2.2-4007 H of the Administrative Process Act and Executive Order Number 21 (02). Section 2.2-4007 H requires that such economic impact analyses include, but need not be limited to, the projected number of businesses or

other entities to whom the regulation would apply, the identity of any localities and types of businesses or other entities particularly affected, the projected number of persons and employment positions to be affected, the projected costs to affected businesses or entities to implement or comply with the regulation, and the impact on the use and value of private property. The analysis presented below represents DPB's best estimate of these economic impacts.

Summary of the proposed regulation. The Board of Nursing (board) proposes to establish 18 VAC 90-25, Regulations Governing Certified Nurse Aids to replace regulatory language concerning nurse aids and nurse aide education programs that currently exists within 18 VAC 90-20, Regulations Governing the Practice of Nursing. The proposed regulations are for the most part identical to current requirements for nurse aide certification and education program approval. The board does propose the following changes: 1) add requirement that nurse aide education programs provide each student with a copy of his certificate of completion, 2) add requirement that all instructional personnel shall have experience in teaching adults or high school students, 3) increase the minimum number of hours of core instruction that students of nurse aide programs must complete prior to their contact with a nursing facility client, 4) add requirement that applicants for licensure by endorsement submit a verification form to the credentialing agency in each state in which the applicant has been registered, certified, or licensed, and 5) add clarifying language.

Estimated economic impact. According to the Department of Health Professions (department), there have been problems with some nurse aide education programs not providing students with a certificate of completion. Consequently, some students have had difficulty demonstrating that they have completed training when applying for employment. The board therefore proposes to require that programs provide each student with a copy of his certificate of completion as a condition for maintaining their approved status. Since certificates of completion are valuable to recipients who are on the job market as proof of their training, this proposal will be beneficial to the extent that nurse aide education programs that have failed to issue certificates of completion change their behavior in response to the proposed requirement.

Under both the current and proposed regulations, instructional personnel for nurse aide education programs must demonstrate competence to teach adults prior to being assigned to teach. The current regulations list the methods by which competence to teach adults can be demonstrated: 1) satisfactorily complete a course on teaching adults, 2) have experience teaching adults, or 3) have experience in supervising nurse aides. The board has found that experience in supervising has not correlated with success in teaching.¹ Thus, the board proposes to remove "experience in supervising nurse aides" as an approved method by which competence to teach adults can be demonstrated. In addition, the board proposes to add experience teaching high school

¹ A formal study was not conducted. This determination was based on anecdotal evidence.

students to the list of methods by which competence to teach adults can be demonstrated.

Potential instructors without teaching experience, who could demonstrate competence through supervision under the current regulations, will instead under the proposed regulations need to satisfactorily complete a course on teaching adults. All instructional personnel must be either a registered nurse or a licensed practical nurse. The median hourly wages for registered nurses and licensed practical nurses in Virginia are \$21.03 and \$14.09, respectively.² According to the department, a half-day of in-house instruction from a current instructor is sufficient to cover the necessary material for a course on teaching adults. Assuming that the value of a nurse's time is equal to her median hourly wage and that the training program lasts 4 hours (one half work day), then the cost for a registered or licensed practical nurse to take the course on teaching adults would be \$84.12 or \$56.36, respectively.³ If the instructors' teaching skills are significantly improved by satisfactorily completing the course, then the benefits of eliminating the supervision option and essentially requiring the course may exceed the course's cost. The amount of the benefit depends on how much the instructors' teaching skills are improved, and how much difference the instructors' improved teaching skills make in the nurse aide students' learning and on-the-job performance. Since no data is available either on how much the course improves instructors' teaching skills, or how much difference the instructors' improved teaching skills make in the learning and on-the-job performance of the nurse aide students, an accurate estimate of the benefits of the effective requirement that instructors without teaching experience take the course cannot be made.

Under both the current and proposed regulations, nurse aide education programs are required to be at least 120 clock hours in length. The current regulations require that students receive at least 16 hours of instruction prior to direct contact with a nursing facility client. The board proposes to increase the minimum number of hours of instruction prior to direct contact with a nursing facility client to 24. The additional eight hours are intended to provide time to cover instruction in fall prevention, dealing with aggressive patients, communicating with sensory-impaired patients, and rules governing practice. According to the department, most nurse aide education programs, if not all, already provide at least 24 hours of classroom instruction prior to students' direct contact with a nursing facility client. Program directors Paula Smoot of Culpepper Baptist Retirement Community and Pamela Lane of Westminster-Canterbury in Richmond concur.⁴ Thus, this proposal will have little impact. For those few programs that do not already have at least 24 hours of classroom instruction prior to students' direct contact with a nursing facility client, the additional pre-contact training may produce a small reduction in the probability of problematic interactions with clients.

The board proposes to require that applicants for licensure by endorsement submit a verification form to the credentialing agency in each state in which the applicant has been registered, certified, or licensed at any time in the past. Under the current regulations, the requirement is only for states where the applicant has been registered, certified, or licensed within the last two years. The board proposes this amendment so as to become informed of any findings of patient neglect, abuse or misappropriation of client property by the applicant that occurred in another state more than two years ago. Since the requirement for the applicant is that he "submit the required verification form to the credentialing agency," not that the department receives the information from other states, the applicant will not be penalized by slow responses to form submissions in other states. Most states, including Virginia, do not charge a fee for submission of verification forms.⁵ Thus, the additional cost to applicants for licensure by endorsement of the proposed amendment is only time it takes to obtain, fill out, and send verification forms to credentialing agencies in states where they were registered, certified, or licensed prior to two years earlier.

To the extent that applicants comply with this proposed requirement, it will be beneficial in that the board will become better aware of past misconduct by applicants for licensure by endorsement. Also, some potential applicants who had been found guilty of misconduct more than two years ago may become discouraged from applying for licensure by endorsement under the new proposed requirement. Thus, the proposed amendment may help prevent individuals that have demonstrated that their conduct may be dangerous for patients from becoming licensed as nurse aides in Virginia. Since the cost of compliance is relatively small, and the benefit of potentially preventing the exposure of patients to dangerous aides may be large, the proposal to extend the verification form requirement for out-of-state registration, certification, and licensure beyond the previous two years most likely produces a net benefit.

Businesses and entities affected. The proposed amendments affect the estimated 36,000 nurse aides and their patients and employers, the 231 approved nurse aide education programs and their students and staff, as well as individuals and entities that may consider becoming nurse aides or nurse aide education programs, respectively. In addition, registering, certifying, and licensing agencies in other states may be affected by the proposal to require that applicants for licensure by endorsement submit a verification form to the credentialing agency in each state in which the applicant has been registered, certified, or licensed at any time in the past.

Localities particularly affected. The proposed regulations affect all Virginia localities.

Projected impact on employment. The proposed amendments will not significantly affect employment levels.

Effects on the use and value of private property. The proposed amendments will not have a large impact on the use and value of private property.

² Source: U.S. Department of Labor, Bureau of Labor Statistics, 2001 State Occupational Employment and Wage Estimates

³ Calculations: $\$21.03 \times 4 = \84.12 ; $\$14.09 \times 4 = \56.36

⁴ Information obtained through phone interviews.

⁵ Source: Department of Health Professions

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Agency's Response to the Department of Planning and Budget's Economic Impact Analysis: The Board of Nursing generally concurs with the analysis of the Department of Planning and Budget (DPB) for amendments to 18 VAC 90-25 as recommended during a periodic review of regulations.

The board wishes to provide clarification to two sections of the EIA:

It is noted that some students have had difficulty demonstrating that they have completed training when applying for employment. In fact, the more pressing problem is that without a certificate of completion from their training program, they are unable to sit for the competency examination to become a CNA, as required by federal rules for employment in a nursing home. The failure of an educational program to provide a certificate of completion becomes a problem for employment if the nursing assistant wants to work in an assisted living facility or another setting in which it is not required that they be certified but is required that they have training.

There is comment on the proposed amendment to require an applicant to provide information about any finding of patient neglect, abuse or misappropriation of client property that occurred in any state in which they have ever been certified. Such a finding would be cause for denial of certification by the board. To further clarify the need for such a requirement, the agency would add that a long-term care facility that receives federal funds is prohibited by federal rule from employing a CNA who has had any finding of patient neglect, abuse or misappropriation of property.

Summary:

18 VAC 90-25, *Regulations Governing Certified Nurse Aides*, is being proposed to replace existing regulations for nurse aides and nurse aide education programs found within 18 VAC 90-20, *Regulations Governing the Practice of Nursing*. Through its regulatory review, the board determined that a separate set of regulations for nurse aides would be clearer and less cumbersome, especially for nurse aide education programs that have specific criteria for establishing and maintaining an approved program. The proposed regulations are identical to current requirements for nurse aide certification and educational program approval with the exception of certain rules identified during regulatory review.

Proposed amendments to the program requirements clarify instructional expectations of the board for maintaining approval to provide nurse aide education, including an increase in the core curriculum from 16 to 24 hours and inclusion of instruction in fall prevention and care of sensory-impaired clients. The process for reporting to the board and for an interruption in the program is also clarified. Regulations for reinstatement of nurse aide certification have been amended to include a prohibition against reinstatement following a finding of abuse, neglect or misappropriation of property and a board guidance document that provides for the possibility of reinstatement if the finding of neglect was based on a single occurrence. As with the nursing regulations, there are additional grounds

added to the disciplinary provisions that address situations encountered in disciplinary cases before the board.

CHAPTER 25.

REGULATIONS GOVERNING CERTIFIED NURSE AIDES.

PART I.

NURSE AIDE EDUCATION PROGRAMS.

18 VAC 90-25-10. Definitions.

The following words and terms when used in this chapter shall have the following meanings, unless the context clearly indicates otherwise:

"Board" means the Virginia Board of Nursing.

"Committee" means the Education Special Conference Committee, comprised of not less than two members of the board in accordance with § 2.2-4019 of the Code of Virginia.

"Nurse aide education program" means a program designed to prepare nurse aides for certification.

"Nursing facility" means a licensed nursing home or an entity that is certified for Medicare or Medicaid long-term care reimbursement and licensed or certified by the Virginia Department of Health.

"Primary instructor" means a registered nurse who is responsible for teaching and evaluating the students enrolled in a nurse aide education program.

"Program coordinator" means a registered nurse who is administratively responsible and accountable for a nurse aide education program.

"Program provider" means an entity that conducts a nurse aide education program.

18 VAC 90-25-20. Establishing and maintaining a nurse aide education program.

A. Establishing a nurse aide education program.

1. A program provider wishing to establish a nurse aide education program shall submit an application to the board at least 90 days in advance of the expected opening date.
2. The application shall provide evidence of the ability of the institution to comply with subsection B of this section.
3. The committee shall, in accordance with § 2.2-4019 of the Code of Virginia, receive and review the application and shall make a recommendation to the board to grant or deny approval.
4. If the committee's recommendation is to deny approval, no further action will be required of the board unless the program requests a hearing before the board or a panel thereof in accordance with § 2.2-4020 and subdivision 11 of § 54.1-2400 of the Code of Virginia.

B. Maintaining an approved nurse aide education program. To maintain approval, the nurse aide education program shall:

1. Demonstrate evidence of compliance with the following essential elements:

a. Curriculum content and length as set forth in subsection A of 18 VAC 90-25-40 and subsection C of 18 VAC 90-25-50.

b. Maintenance of qualified instructional personnel as set forth in 18 VAC 90-25-30.

c. Classroom facilities that meet requirements set forth in subsection D of 18 VAC 90-25-50.

d. Maintenance of records as set forth in subsection A of 18 VAC 90-25-50.

e. Skills training experience in a nursing facility that has not been subject to penalty or penalties as provided in 42 CFR 483.151(b)(2) (Medicare and Medicaid Programs: Nurse Aide Training and Competency Evaluation Programs, effective April 1, 1992) in the past two years. The foregoing shall not apply to a nursing facility that has received a waiver from the state survey agency in accordance with federal law.

f. Agreement that board representatives may make unannounced visits to the program.

g. Financial support and resources sufficient to meet requirements of this chapter as evidenced by a copy of the current annual budget or a signed statement from the administration specifically detailing its financial support and resources.

h. Completion and submission of biennial on-site review reports and program evaluation reports as requested by the board.

2. Impose no fee for any portion of the program on any nurse aide who, on the date on which the nurse aide begins the program, is either employed or has an offer of employment from a nursing facility.

3. Provide documentation that each student applying to or enrolled in such program has been given a copy of applicable Virginia law regarding criminal history records checks for employment in certain health care facilities, and a list of crimes that pose a barrier to such employment.

4. Report all substantive changes in subdivision 1 of this subsection within 10 days of the change to the board to include, but not be limited to, a change in the program coordinator, primary instructor, program ownership, or licensure status.

5. Provide each student with a copy of his certificate of completion.

18 VAC 90-25-30. Requirements for instructional personnel.

A. Program coordinator.

1. Each program shall have a program coordinator who must be a registered nurse.

2. The program coordinator in a nursing facility based program may be the director of nursing services. The director of nursing may assume the administrative responsibility and accountability for the nurse aide

education program but shall not engage in the actual classroom and clinical teaching.

3. The primary instructor may be the program coordinator in any nurse aide education program.

B. Primary instructor.

1. Each program shall have a primary instructor who must be a registered nurse.

2. Qualifications. The primary instructor, who does the majority of the actual teaching of the students shall:

a. Hold a current, unrestricted Virginia license as a registered nurse; and

b. Have two years of experience as a registered nurse within the previous five years and at least one year of experience in the provision of long-term care facility services. Such experience may include, but not be limited to, employment in a nurse aide education program or employment in or supervision of nursing students in a nursing facility or unit, geriatrics department, chronic care hospital, home care or other long-term care setting. Experience should include varied responsibilities, such as direct resident care, supervision and education.

3. Responsibilities. The primary instructor is responsible for the teaching and evaluation of students and, in addition, shall:

a. Participate in the planning of each learning experience;

b. Ensure that course objectives are accomplished;

c. Ensure that the provisions of subsection F of this section are maintained;

d. Maintain records as required by subsection A of 18 VAC 90-25-50;

e. Perform other activities necessary to comply with subsection B of 18 VAC 90-25-20; and

f. Ensure that students do not perform services for which they have not received instruction and been found proficient by the instructor.

C. Other instructional personnel.

1. Instructional personnel who assist the primary instructor in providing classroom or clinical supervision shall be registered nurses or licensed practical nurses.

a. A registered nurse shall:

(1) Hold a current, unrestricted Virginia license as a registered nurse; and

(2) Have had at least one year of direct patient care experience as a registered nurse.

b. A licensed practical nurse shall:

(1) Hold a current, unrestricted Virginia license as a practical nurse;

(2) Hold a high school diploma or equivalent;

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(3) Have been graduated from a state-approved practical nursing program; and

(4) Have had at least two years of direct patient care experience as a licensed practical nurse.

2. *Responsibilities.* Other instructional personnel shall provide instruction under the supervision of the primary instructor.

D. Prior to being assigned to teach the nurse aide education program, all instructional personnel shall demonstrate competence to teach adults by one of the following:

1. Satisfactory completion of a course in teaching adults that includes (i) basic principles of adult learning; (ii) teaching methods and tools for adult learners; and (iii) evaluation strategies and measurement tools for assessing the learning outcomes; or

2. Have experience in teaching adults or high school students.

E. To meet planned program objectives, the program may, under the direct, on-site supervision of the primary instructor, use other persons who have expertise in specific topics and have had at least one year of experience in their field.

F. When students are giving direct care to clients in clinical areas, instructional personnel must be on site solely to supervise the students. The ratio of students to each instructor shall not exceed 10 students to one instructor.

18 VAC 90-25-40. Requirements for the curriculum.

A. *Curriculum content.* The curriculum shall include, but shall not be limited to, classroom and clinical instruction in the following:

1. *Initial core curriculum.* Prior to the direct contact of a student with a nursing facility client, a total of at least 24 hours of instruction in the following areas must be presented:

- a. Communication and interpersonal skills.
- b. Infection control.
- c. Safety and emergency procedures, including dealing with obstructed airways and fall prevention.
- d. Promoting client independence.
- e. Respecting clients' rights.

2. *Basic skills.*

- a. Recognizing changes in body functioning and the importance of reporting such changes to a supervisor.
- b. Measuring and recording routine vital signs.
- c. Measuring and recording height and weight.
- d. Caring for the clients' environment.
- e. Measuring and recording fluid and food intake and output.
- f. Performing basic emergency measures.

g. Caring for a client when death is imminent.

3. *Personal care skills.*

- a. Bathing and oral hygiene.
- b. Grooming.
- c. Dressing.
- d. Toileting.
- e. Assisting with eating and hydration, including proper feeding techniques.
- f. Caring for skin, to include prevention of pressure ulcers.
- g. Transfer, positioning and turning.

4. *Individual client's needs, including mental health and social service needs.*

- a. Modifying the aide's behavior in response to the behavior of clients.
- b. Identifying developmental tasks associated with the aging process.
- c. Demonstrating principles of behavior management by reinforcing appropriate behavior and causing inappropriate behavior to be reduced or eliminated.
- d. Demonstrating skills supporting age-appropriate behavior by allowing the client to make personal choices, and by providing and reinforcing other behavior consistent with the client's dignity.
- e. Utilizing the client's family or concerned others as a source of emotional support.
- f. Responding appropriately to the client's behavior; including, but not limited to, aggressive behavior and language.
- g. Providing appropriate clinical care to the aged and disabled.
- h. Providing culturally sensitive care.

5. *Care of the cognitively or sensory (visual and auditory) impaired client.*

- a. Using techniques for addressing the unique needs and behaviors of individuals with dementia (Alzheimer's and others).
- b. Communicating with cognitively or sensory impaired residents.
- c. Demonstrating an understanding of and responding appropriately to the behavior of cognitively or sensory impaired residents.
- d. Using methods to reduce the effects of cognitive impairment.

6. *Skills for basic restorative services.*

- a. Using assistive devices in transferring, ambulation, eating and dressing.
- b. Maintaining range of motion.

- c. Turning and positioning, both in bed and chair.
- d. Bowel and bladder training.
- e. Caring for and using prosthetic and orthotic devices.
- f. Teaching the client in self-care according to the client's abilities as directed by a supervisor.

7. Clients' rights.

- a. Providing privacy and maintaining confidentiality.
- b. Promoting the client's right to make personal choices to accommodate individual needs.
- c. Giving assistance in resolving grievances and disputes.
- d. Providing assistance necessary to participate in client and family groups and other activities.
- e. Maintaining care and security of the client's personal possessions.
- f. Promoting the resident's rights to be free from abuse, mistreatment and neglect and the need to report any instances of such treatment to appropriate staff.
- g. Avoiding the need for restraints in accordance with current professional standards.

8. Legal and regulatory aspects of practice as a certified nurse aide, including, but not limited to, consequences of abuse, neglect, misappropriation of patient property and unprofessional conduct.

9. Occupational health and safety measures.

10. Appropriate management of conflict.

B. Unit objectives.

- 1. Objectives for each unit of instruction shall be stated in behavioral terms that are measurable.
- 2. Objectives shall be reviewed with the students at the beginning of each unit.

C. Curriculum changes. Changes in curriculum shall be approved by the board prior to implementation and shall be submitted at the time of the on-site visit or with the report submitted by the program coordinator in the intervening year.

18 VAC 90-25-50. Other program requirements.

A. Records.

- 1. Each nurse aide education program shall develop and maintain an individual record of major skills taught and the date of performance by the student. At the completion of the nurse aide education program, the nurse aide must receive a copy of this record and a certificate of completion from the program.
- 2. A record of the reports of graduates' performance on the approved competency evaluation program shall be maintained.
- 3. A record that documents the disposition of complaints against the program shall be maintained.

B. Student identification. The nurse aide students shall wear identification that clearly distinguishes them as a "nurse aide student."

C. Length of program.

- 1. The program shall be at least 120 clock hours in length.
- 2. The program shall provide for at least 24 hours of instruction prior to direct contact of a student with a nursing facility client.
- 3. Skills training in clinical settings shall be at least 40 hours of providing direct client care. Five of the clinical hours may be in a setting other than a nursing home. Hours of observation shall not be included in the required 40 hours of skills training.
- 4. Employment orientation to facilities used in the education program must not be included in the 120 hours allotted for the program.

D. Classroom facilities. The nurse aide education program shall provide facilities that meet federal and state requirements including:

- 1. Comfortable temperatures.
- 2. Clean and safe conditions.
- 3. Adequate lighting.
- 4. Adequate space to accommodate all students.
- 5. Instructional technology and equipment needed for simulating resident care.

18 VAC 90-25-60. Requirements for continued approval; interruption or closing of a program.

A. Program review.

- 1. Each nurse aide education program shall be reviewed annually either by a visit on site by an agent of the board or by a written program evaluation. Each program shall be reviewed by an on-site visit at least every two years following initial review.
- 2. The program coordinator shall prepare and submit a program evaluation report on a form provided by the board in the intervening year that an on-site review is not conducted.
- 3. The committee, in accordance with § 2.2-4019 of the Code of Virginia, shall receive and review the report of the on-site visit or program evaluation report and shall make recommendations to the board to grant or deny continued approval.
 - a. A nurse aide education program shall continue to be approved provided the requirements set forth in subsection B of 18 VAC 90-25-20 are maintained.
 - b. If the committee determines that a nurse aide education program has not filed its program evaluation report or is not maintaining the requirements of subsection B of 18 VAC 90-25-20, the committee may recommend to the board that the program be placed on conditional approval and the program provider shall be

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given a reasonable period of time to correct the identified deficiencies or the matter shall be referred to the board or a panel of the board for a hearing.

(1) The committee shall receive and review reports of progress toward correcting identified deficiencies and, when a final report is received at the end of the specified time showing corrections of deficiencies, make a recommendation to the board for grant of continued approval.

(2) If the program provider fails to correct the identified deficiencies within the time specified by the committee or the board, the board or a panel thereof may withdraw approval following a hearing in accordance with § 2.2-4020 and subdivision 11 of § 54.1-2400 of the Code of Virginia.

(3) The program provider may request a formal hearing before the board or a panel thereof pursuant to § 2.2-4020 and subdivision 11 of § 54.1-2400 of the Code of Virginia if it objects to any action of the board relating to conditional approval.

B. Interruption of program.

1. When a program provider does not hold classes for a period not to exceed one year, the provider may request that the program be placed on inactive status and shall not be subject to compliance with subsection B of 18 VAC 90-25-20 for the specified time.

2. Unless the program provider notifies the board that it intends to admit students, the program will be considered closed at the end of the one-year period and be subject to the requirements of subsection C of this section.

3. If the program provider does not hold classes for two consecutive years, the program shall be considered closed and shall be subject to the requirements of subsection C of this section.

C. Closing of a nurse aide education program. When a nurse aide education program closes, the program provider shall:

1. Notify the board of the date of closing.

2. Submit to the board a list of all graduates with the date of graduation of each.

PART II.

CERTIFICATION OF NURSE AIDES.

18 VAC 90-25-70. Initial certification for the nurse aide registry.

A. The executive director of the board shall issue a certificate as a certified nurse aide to each applicant who qualifies for such a certificate under §§ 54.1-3024, 54.1-3025, 54.1-3026 and 54.1-3028 of the Code of Virginia and provisions of this chapter.

B. Nurse aide competency evaluation.

1. The board may contract with a test service for the development and administration of a competency evaluation.

2. All individuals completing a nurse aide education program in Virginia shall successfully complete the competency evaluation required by the board prior to making application for certification and to using the title Certified Nurse Aide.

3. The board shall determine the minimum passing standard on the competency evaluation.

C. Initial certification.

1. To be placed on the registry and certified by examination, the nurse aide must:

a. (i) Satisfactorily complete a nurse aide education program approved by the board; (ii) be enrolled in a nursing education program preparing for registered nurse or practical nurse licensure, and have satisfactorily completed at least one clinical nursing course that includes at least 40 hours of clinical experience involving direct client care; or (iii) have completed a nursing education program preparing for registered nurse licensure or practical nurse licensure;

b. Pass the competency evaluation required by the board; and

c. Submit the required application and fee as prescribed by the board.

2. To be placed on the registry and be certified by endorsement, the nurse aide must:

a. Be a graduate of a state-approved nurse aide education program;

b. Have satisfactorily completed a competency evaluation program;

c. Be currently registered in another state, with no finding of abuse, neglect or misappropriation of property;

d. Submit the required application; and

e. Submit the required verification form to the credentialing agency in each state in which the applicant has been registered, certified or licensed.

3. Initial certification shall be for two years.

18 VAC 90-25-80. Renewal or reinstatement of certification.

A. Renewal of certification.

1. No less than 30 days prior to the expiration date of the current certification, an application for renewal shall be mailed by the board to the last known address of each currently registered certified nurse aide.

2. The certified nurse aide shall return the completed application with the required fee of \$45 and verification of performance of nursing-related activities for compensation within the two years immediately preceding the expiration date.

3. Failure to receive the application for renewal shall not relieve the certificate holder of the responsibility for renewing the certification by the expiration date.

4. A certified nurse aide who has not performed nursing-related activities for compensation during the two years preceding the expiration date of the certification shall repeat and pass the nurse aide competency evaluation prior to applying for recertification.

5. The board shall also charge a fee of \$25 for a returned check.

B. Reinstatement of certification.

1. An individual whose certification has lapsed for more than 90 days shall file the required application and renewal fee and provide:

a. Verification of performance of nursing-related activities for compensation in the two years prior to the expiration date of the certificate and within the preceding two years; or

b. When nursing activities have not been performed during the preceding two years, evidence of having repeated and passed the nurse aide competency evaluation.

2. An individual who has previously had a finding of abuse, neglect or misappropriation of property is not eligible for reinstatement of his certification, except as provided in subsection C of this section.

C. If a finding of neglect was made against a certificate holder based on a single occurrence, an individual may petition for removal of the finding of neglect provided:

1. A period of at least one year has passed since the finding was made; and

2. The individual seeking reinstatement demonstrates sufficient evidence that employment and personal history do not reflect a pattern of abusive behavior or neglect.

18 VAC 90-25-90. Requirements for certified nurse aides.

A. Evidence of change of name. A certificate holder who has changed his name shall submit as legal proof to the board a copy of the marriage certificate or court order authorizing the change. A duplicate certificate shall be issued by the board upon receipt of such evidence and the required fee.

B. Requirements for current mailing address.

1. All notices required by law and by this chapter to be mailed by the board to any certificate holder shall be validly given when mailed to the latest address on file with the board.

2. Each certificate holder shall maintain a record of his current mailing address with the board.

3. Any change of address by a certificate holder shall be submitted in writing to the board within 30 days of such change.

18 VAC 90-25-100. Disciplinary provisions for nurse aides.

The board has the authority to deny, revoke or suspend a certificate issued, or to otherwise discipline a certificate holder upon proof that he has violated any of the provisions of § 54.1-3007 of the Code of Virginia. For the purpose of

establishing allegations to be included in the notice of hearing, the board has adopted the following definitions:

1. Fraud or deceit in order to procure or maintain a certificate shall mean, but shall not be limited to:

a. Filing false credentials;

b. Falsely representing facts on an application for initial certification, reinstatement or renewal of a certificate; or

c. Giving or receiving assistance in taking the competency evaluation.

2. Unprofessional conduct shall mean, but shall not be limited to:

a. Performing acts beyond those authorized for practice as a nurse aide as defined in Chapter 30 (§ 54.1-3000 et seq.) of Title 54.1 of the Code of Virginia, and beyond those authorized by the Drug Control Act (§ 54.1-3400 et seq. of the Code of Virginia) or by provisions for delegation of nursing tasks in Part X (18 VAC 90-20-420 et seq.) of 18 VAC 90-20.

b. Assuming duties and responsibilities within the practice of a nurse aide without adequate training or when competency has not been maintained;

c. Obtaining supplies, equipment or drugs for personal or other unauthorized use;

d. Falsifying or otherwise altering client or employer records, including falsely representing facts on a job application or other employment-related documents;

e. Abusing, neglecting or abandoning clients;

f. Having been denied a license or certificate or having had a license or certificate issued by the board revoked or suspended;

g. Giving to or accepting from a patient or client property or money for any reason other than fee for service or a nominal token of appreciation;

h. Obtaining money or property of a patient or client by fraud, misrepresentation or duress;

i. Entering into a relationship with a patient or client that constitutes a professional boundary violation in which the nurse aide uses his professional position to take advantage of a client's vulnerability, to include but not limited to actions that result in personal gain at the expense of the patient, an inappropriate personal involvement or sexual conduct with a patient; or

j. Violating state or federal laws relating to the privacy of patient information, including but not limited to § 32.1-127.1:03 of the Code of Virginia.

3. For the purposes of interpreting provisions of § 54.1-3007 (7) of the Code of Virginia, a restriction on nurse aide certification shall be interpreted as having a finding of abuse, neglect or misappropriation of patient property made in another state or being placed on the abuse registry in another state.

Proposed Regulations

NOTICE: The forms used in administering 18 VAC 90-25, Regulations Governing Certified Nurse Aides, are not being published due to the large number; however, the name of each form is listed below. The forms are available for public inspection at the Department of Health Professions, 6603 West Broad Street, Richmond, Virginia, or at the office of the Registrar of Regulations, General Assembly Building, 2nd Floor, Richmond, Virginia.

FORMS

Instructions for Application for Nurse Aide Certification by Endorsement (rev. 12/02).

Application for Nurse Aide Certification by Endorsement (rev. 12/02).

Nurse Aide Certification Verification Form (rev. 12/02).

Instructions for Applicant for Advanced Certified Nurse Aide Registration (eff. 2/03).

Application for Certification as Advanced Certified Nurse Aide (eff. 2/03).

Instructions for Application for Reinstatement of Nurse Aide Certification (rev. 12/02).

Application for Reinstatement of Nurse Aide Certification (rev. 12/02).

Instructions for Application for Reinstatement of Advanced Nurse Aide Certification (eff. 2/03).

Application for Reinstatement of Advanced Nurse Aide Certification (eff. 2/03).

Application to Establish Nurse Aide Education Program (rev. 12/02).

Application to Establish an Advanced Certification Nurse Aide Education Program (eff. 12/02).

Nurse Aide Education Program Evaluation Report (rev. 11/02).

Nurse Aide Education Program - On-site Review Report (rev. 11/02).

Advanced Certification Nurse Aide Education Program - On-site Review Report (eff. 12/02).

Evaluation of On-Site Visitor (rev. 12/02).

Request for Statistical Information (rev. 12/02).

Renewal Notice and Application, 1401, Certified Nurse Aide (rev. 12/02).

Renewal Notice and Application, Advanced Certified Nurse Aide (eff. 12/02).

VA.R. Doc. No. R02-143B; Filed December 9, 2003, 2:51 p.m.

BOARD OF PHARMACY

Title of Regulation: 18 VAC 110-20. Regulations Governing the Practice of Pharmacy (amending 18 VAC 110-20-10 through 18 VAC 110-20-40, 18 VAC 110-20-60 through 18 VAC 110-20-90, 18 VAC 110-20-105, 18 VAC 110-20-110 through 18 VAC 110-20-220, 18 VAC 110-20-240, 18 VAC 110-20-250, 18 VAC 110-20-280, 18 VAC 110-20-285, 18 VAC 110-20-330, 18 VAC 110-20-350, 18 VAC 110-20-355, 18 VAC 110-20-360, 18 VAC 110-20-410, 18 VAC 110-20-412, 18 VAC 110-20-415, 18 VAC 110-20-420, 18 VAC 110-20-440 through 18 VAC 110-20-470, 18 VAC 110-20-490, 18 VAC 110-20-500, 18 VAC 110-20-510, 18 VAC 110-20-530, 18 VAC 110-20-540, 18 VAC 110-20-550, 18 VAC 110-20-555, 18 VAC 110-20-590, 18 VAC 110-20-680 through 18 VAC 110-20-710; adding 18 VAC 110-20-121; repealing 18 VAC 110-20-370, 18 VAC 110-20-380, 18 VAC 110-20-480).

Statutory Authority: §§ 54.1-103 and 54.1-2400 and Chapters 33 (§ 54.1-3300 et seq.) and 34 (§ 54.1-3400 et seq.) of Title 54.1 of the Code of Virginia.

Public Hearing Date: January 14, 2004 - 9 a.m.

Public comments may be submitted until February 27, 2004.
(See Calendar of Events section for additional information)

Agency Contact: Elaine J. Yeatts, Agency Regulatory Coordinator, Department of Health Professions, 6603 West Broad Street, Richmond, VA 23230-1712, telephone (804) 662-9918, FAX (804) 662-9114, or e-mail elaine.yeatts@dhp.state.va.us.

Basis: Section 54.1-2400 of the Code of Virginia establishes the general powers and duties of health regulatory boards including the responsibility to promulgate regulations, levy fees, administer a licensure and renewal program, and discipline regulated professionals.

The specific authority to issue licenses and permits to pharmacists and pharmacies and to control the sale and dispensing of prescription drugs is found in Chapters 33 (§ 54.1-3300 et seq.) and 34 (§ 54.1-3400 et seq.) of Title 54.1 of the Code of Virginia.

Purpose: The agency is recommending that the regulation be amended in order to address the numerous questions and recommendations that arose from the periodic review conducted by board members and advisors from all aspects of pharmacy practice. In some cases, there is a need for clarification of a rule; in others, there is a need to amend the regulation to allow the practice of pharmacy to be more responsive to patient needs and changing times.

The Code of Virginia requires the Board of Pharmacy to regulate the practice of pharmacy and the manufacturing, dispensing, selling, distributing, processing, compounding or disposal of drugs and devices. Among the criteria to be considered in its regulations, the board is charged with maintenance of the quality, quantity, integrity, safety and efficacy of drugs or devices distributed, dispensed or administered and with safeguarding against the diversion of drugs and devices (§ 54.1-3307). Therefore, while the regulatory amendments proposed are intended to remove unnecessary barriers to the licensure of pharmacists and to

the efficient, cost-effective practice of pharmacy, the board's primary obligation is to ensure that the safety and efficacy of prescription drugs are not compromised.

The board has amended regulations that restrict practice or inhibit modernization and utilization of newer technology, provided the change is within the parameters of law and federal rules and provided it is good policy that protects the health, safety and welfare of the public.

Substance:

PART I. GENERAL PROVISIONS.

Under the section on definitions, the board has included commonly used acronyms and has amended the term "pharmacist-in-charge" to "PIC" throughout the regulation, which is now defined. The term "on duty" is defined according to the definition that is now board policy in a guidance document.

There are no changes in the amount of the current fees being charged; the amendments are intended to group fees into listings for ease of compliance. However, there are changes in policies intended to reduce the financial burden on a person who is late in renewing a license or who has a lapsed license and is seeking reinstatement. One new fee for a reinspection is established.

PART II. LICENSURE REQUIREMENTS FOR PHARMACISTS

Changes to licensure requirements for practical experience were adopted for clarification and consistency with the law. This section was also amended to address a problem of some applicants for licensure from other states, where the licensing board relies on the pharmacy school to certify hours of practical experience; the board modified the regulation to accept such certification. To alleviate a problem experienced by some applicants for licensure by endorsement, the board has amended its regulation to accept verification of practical experience hours worked as a pharmacist in another state within the United States in lieu of intern hours in order to meet the practical experience requirement.

An amendment to subsection D clarifies the meaning of a requirement for six months of practical experience as a pharmacy intern as a minimum of 1,000 hours of practical experience for clarity to the applicants. Amendments to the requirements for foreign trained applicants were necessary to make it clear to graduates of foreign colleges of pharmacy that it is necessary for them to meet all requirements for foreign graduates prior to sitting for the NAPLEX and law examination.

Rules for reinstatement are less burdensome, since an applicant would no longer be required to pay all back renewal fees. Likewise, amendments will facilitate the reactivation or reinstatement of an inactive or lapsed license by capping the number of required CE hours at five years, not to exceed a total of 60 hours. To address concerns about pharmacists whose licenses have been suspended, lapsed or inactive for more than five years, the board will also require passage of the board-approved law examination and documentation of either active practice in another state or practical experience of at least 160 hours within the past six months as a pharmacy intern.

PART III. REQUIREMENTS FOR PHARMACY TECHNICIAN REGISTRATION.

Amendments to modify board policy on renewal and reinstatement will allow licensees more time to submit a late renewal and will alleviate the financial burden for some applicants for reinstatement.

PART IV. PHARMACIES.

The board has adopted a less restrictive rule for serving as the pharmacist-in-charge to allow a pharmacist to serve as PIC at two pharmacies rather than just one. The board has also adopted a specific rule that a PIC who is absent from practice for more than 30 consecutive days shall be deemed to no longer be the PIC and set rules for notification to the board.

An amendment will require the policy and procedure manual to include the schedules of drugs to be maintained if a pharmacy applies for a special or limited use permit; that information could affect the advisability of issuing such a permit.

Requirements for notice of a pharmacy closing or change of ownership and for a change in the hours are clarified to ensure that the board and public are properly notified as soon as possible and to identify the person responsible for providing notice.

Amendment will clarify that if a pharmacy makes changes to a previously approved security system, it must be re-approved to ensure that the new security system is adequate to protect against theft or loss. The board also has established a reinspection fee of \$150. An amended rule will allow the pharmacy to open and begin operation once approval is given by the inspector or board staff.

There are several amendments clarifying the square footage required for a pharmacy and eliminating unnecessary requirements on minimum standards, equipment and resources.

Amendments to the section on access to the prescription department in the absence of a pharmacist are added to allow a pharmacy technician, with permission of a pharmacist employed at that pharmacy, to disable the alarm and enter the pharmacy accompanied by management to retrieve prescriptions which had already been filled and checked by a pharmacist. That entry would have to be fully documented, and the access code changed by the PIC after such an event.

Amendments are adopted to ensure that there are written procedures detailing security of the dispensed prescriptions if a prescription is delivered at a time when the pharmacist is not present and to allow the pharmacy to keep the cabinet, drawer, or safe containing Schedule II drugs unlocked during hours that the prescription department is open and a pharmacist is on duty.

PART V. NUCLEAR PHARMACIES

Amended language requires nuclear pharmacies to have adequate space and equipment, commensurate with the scope of services in compliance with standards and requirements of the Nuclear Regulatory Commission (NRC)

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and the Virginia Department of Health. A new subsection set forth rules for the dispensing of radiopharmaceuticals to include requirements for the content and transmission of the order.

PART VI. DRUG INVENTORY AND RECORDS

An amendment will specify which records must be maintained at the same location as the stock of drugs to which the records pertain to include executed order forms, prescriptions, and inventories of Schedule II through V drugs. The board will allow off-site storage of other records, such as invoices, if so allowed by the DEA.

The board has made a provision to allow an electronic image of a prescription to be maintained in an electronic database in lieu of a hard copy file for Schedule VI prescriptions. An amendment would also permit a pharmacy to use an automated record as the prescription rather than a hard copy or electronic image if the pharmacy system's automated data processing system fields are automatically populated by an electronic transmission.

PART VII. PRESCRIPTION ORDER AND DISPENSING STANDARDS

Amendments are intended to clarify the requirements for transmission of prescriptions by facsimile device (fax) and will allow forwarding a faxed chart order from a long term care facility or from a hospice. Amendments to the section on electronic transmission of Schedule II-V prescriptions specify that such transmission must comply with any security or other requirements of federal law and with all security requirements of state law related to privacy of protected health information. Another amendment will relieve the burden of having to maintain a hard copy of an electronically transmitted prescription, if the record is maintained in accordance with requirements on automated data processing.

PART VIII. LABELING AND PACKAGING STANDARDS FOR PRESCRIPTIONS

Requirements for use of the generic name of the drug on the prescription label are eliminated for drugs dispensed to patients of a hospital or long term care facility where all drugs are administered by persons licensed to administer. The rule on requesting nonspecial packaging has been amended to adopt the less restrictive federal rule. Rather than specifying guidance for determination of an expiration date to be used on a drug that is being repackaged, the board has amended the regulation to require the pharmacist to determine the appropriate date in accordance with USP guidelines. Requirements for drug products in automated dispensing devices have been amended to ensure that the older drug product is used first and that drugs cannot remain mixed in the lot past their expiration date.

PART IX. STANDARDS FOR PRESCRIPTION TRANSACTIONS.

The rules for transfer of a copy of a prescription have been amended to provide for transfer between two pharmacies of a prescription whether it has been filled or not. Rules have also been amended to allow for electronic transfer without a pharmacist from the provider pharmacy having to "release" the

prescription. Other amendments restate the rules in a clearer format.

Rules on issuing a copy of a prescription that cannot be refilled are repealed, since current pharmacy practice is to provide the patient with a printout of prescriptions rather than a copy of the actual prescription. Likewise, rules on confidentiality of patient information are repealed because it is superceded by state and federal law on patient privacy and is therefore unnecessary and may be in conflict.

Rules for physicians who hold a permit from the board to dispense drugs to the public when pharmacy services are not reasonably available in their geographic area have been updated to specify those sections of the regulations with which the permitted physician must comply and to state that a physician may apply for a special or limited use permit.

PART X. COMPOUNDING STERILE PHARMACEUTICAL PRODUCTS.

This section is amended to clarify that a policy and procedure for the compounding, dispensing and delivery of sterile products should be consistent with USP-NF standards and guidance and to clarify the requirement for certification of laminar flow hoods or other environmental control devices.

PART XI. UNIT DOSE DISPENSING SYSTEMS.

The amendment to the section on transmission of a verbal order to a nurse or pharmacist at the hospital is intended to allow such transmission when such a practitioner is not an employee of the hospital, since some health care workers are employed by agencies and work under contract with a hospital.

PART XII. PHARMACY SERVICES TO HOSPITALS.

Rather than requiring a monthly review of drug therapy for any patient in the hospital for one month or greater, the amended regulation requires the pharmacist to maintain a policy and procedure manual for providing reviews of drug therapy to include at a minimum any irregularities in drug therapy, drug interactions, drug administration, or transcription errors.

Amendments will allow receipts of floor stock drugs and the records that are used to document administration of Schedule II through V drugs to be maintained by the hospital pharmacy in offsite storage provided they are retrievable and can be made available for inspection or audit within 48 hours of a request by the board or an authorized agent. The board also will allow hospital pharmacies to fulfill the requirement for separation of schedule II records for administration by listing schedule II drugs in a separate section on a page that contains other schedules of drugs. Further, amendments will require that an automated device used to dispense drugs in a hospital be able to produce a report for each discrepancy in the count of a drug on hand in the device and that each report be resolved by the PIC or his designee within 72 hours of the time the discrepancy was discovered. The discrepancy must either be resolved or reported to the board as a theft in accordance with statute.

At the request of the hospital subcommittee, the board has specified that certain controlled substances such syringes, contrast media and other schedule VI medical devices and

drugs such as IV solutions could be maintained in locations other than the pharmacy and ordering and distribution delegated to non-pharmacy personnel. Security and storage requirements for these types of controlled substances need to be set forth in the hospital policy and procedure manual and must be checked monthly by the pharmacist-in-charge.

The current rule on dispensing by hospital pharmacies to persons other than their own patients has been repealed.

PART XIII. PHARMACY SERVICES TO LONG TERM CARE FACILITIES.

Amendments on the transfer of drugs for destruction or return and the requirements for an emergency drug kit or a stat drug box are clarified.

Amendments will allow for an expansion of the use of automated dispensing devices in long term care facilities to include provisions to ensure the security of the drugs, control by the pharmacy, removal only upon a valid prescription from a prescriber, and loading of the device by a pharmacist or technician specifically trained in its use. An amendment for limited use of floor stock clarifies the "persons licensed to administer" means nurses or physician assistants.

PART XIV. OTHER INSTITUTIONS AND FACILITIES

Amendments to this section will in correctional facilities: (i) allow the use of the patient name rather than the prescription number on the record; (ii) allow for unused or discontinued drugs to be returned to the provider pharmacy or to a secondary pharmacy within 30 days; (iii) allow drugs to be forwarded by a pharmacist from the correctional facility to a returns company; and (iv) add that drugs may be stocked at a medical clinic or surgery center that is part of the facility and is staffed by one or more physicians providing the clinic applies for and receives a controlled substance registration.

PART XV. EXEMPTED STIMULANT OR DEPRESSANT DRUGS AND CHEMICAL PREPARATIONS

There were no amendments adopted.

PART XVI. MANUFACTURERS, WHOLESALE DISTRIBUTORS, WAREHOUSERS, AND MEDICAL EQUIPMENT SUPPLIERS

An amendment will permit the original order to be kept at a centralized office as long as it is readily retrievable within 48 hours and a copy of the order is kept on the premises of the dispensing supplier.

PART XVII. CONTROLLED SUBSTANCES REGISTRATION FOR OTHER PERSONS OR ENTITIES.

Amendments require that nursing homes without in-house pharmacies that use automated drug dispensing systems have a controlled substances registration (CSR) in order to maintain a stock of drugs. Therefore, nursing homes are added to the list of entities authorized or required to obtain a CSR. There is also a clarification that a pharmacist must supervise the controlled substances in a nursing home without an in-house pharmacy. Finally, an amendment would clarify that an alarm system is not required for researchers or animal control officers.

Issues:

The primary advantages and disadvantages to the public, such as individual private citizens or businesses, of implementing the new or amended provisions: Amendments that facilitate licensure or economically benefit a pharmacy have been adopted with safeguards to ensure minimal competency and drug security and effectiveness. The following are examples of changes that will benefit both licensed pharmacies and the public they serve by improving the availability of pharmacy services, encouraging efficiencies and the use of electronic storage, and assisting in the adoption of cost-saving automation:

1. Changes in the requirements for reinstatement may serve as an incentive to former licensees who now practice in other states to return to practice in Virginia. Eliminating the requirement for all back renewal fees to be paid and capping the hours of required continuing education may facilitate licensure for a few applicants. In addition, the acceptance of hours of active practice in another state in lieu of practical experience in an internship may facilitate initial licensure for a few applicants. The public is benefited if the number of licensed pharmacists can be increased, which could result in cost-savings and improved oversight of pharmacy services.

2. Each pharmacy is required by law to have a pharmacist-in-charge (PIC), but the board is aware of the difficulty many experience in finding pharmacists who are willing to assume responsibility for serving as the PIC. To alleviate this problem and ensure that pharmacies were not left without a pharmacist in charge, the board amended its regulation to permit one pharmacist to be "fully engaged" in the practice of pharmacy and serve as PIC at two locations. The board believes the one pharmacist can adequately oversee two pharmacies without jeopardizing public health and safety. Likewise, the amendment to specify the maximum length of absence of a PIC from the pharmacy will ensure that the pharmacy is not left without a PIC indefinitely or that the PIC who is absent for an extended period remains responsible for a stock of drugs over which he has no control.

3. Amended rules for the inspection and permitting of new pharmacies will ensure that the approval process is as efficient and timely as possible to allow a facility to begin serving the public.

4. Several changes in regulation are designed to facilitate the modernization and efficiency of pharmacies with the intent of encouraging utilization of new technology and adoption of cost-saving measures. By allowing off-site or electronic storage of certain records, both retail and hospital pharmacies will better be able to contain costs. Physical space can better be utilized for the storage and preparation of prescriptions, so long as certain records are readily accessible or obtainable.

5. Efficacies in pharmacy practice, such as the ability to transfer a prescription from one pharmacist to another, authorization to forward a faxed chart order as a prescription, elimination of certain labeling requirements for prescription in hospitals, repeal of the requirement to give a patient a hard copy of each prescription upon request, and the electronic notation of a request for nonspecial packaging, will benefit both the pharmacies and the consumers they serve by

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eliminating unnecessary requirements in getting prescription drugs dispensed to the patient.

6. Automated dispensing devices are now used extensively in hospitals as an efficient means of giving those who administer to patients ready access the drugs prescribed. With certain safeguards, that efficiency will now be available to long term care facilities. While there is a cost associated with leasing the machines, those that wish to utilize these devices will experience a savings since it is less costly than having unit-dose carts manually filled by technicians.

In addition to benefiting from efficiencies in the practice of pharmacy, the public will specifically benefit from the amended regulations in other ways, such as:

7. Currently, there are no provisions for ensuring ability to resume practice for a pharmacist who has been out of practice for more than five years; the board has added a requirement to take the law exam and to verify either active practice in another state or hours in an internship in Virginia. While continuing education is necessary to ensure a pharmacist's knowledge base remains current with the changes in prescription drugs, that is not a substitute for active practice if a pharmacist has allowed his license to lapse for an extended period of time.

8. Clarification of responsibility for notifying the public and the board in situations where a pharmacy is closing or changing its hours will ensure that the public is adequately prepared for such an event and not left without the ability to obtain their prescriptions.

9. New regulations to permit access into the pharmacy by a pharmacy technician and a member of store management in the absence of a pharmacist will greatly facilitate access to prescriptions that have already been filled and verified by the pharmacist as ready for delivery. Safeguards stipulated for such entry should ensure against diversion or any inappropriate or unlawful activity in the absence of the pharmacist.

10. Amended provisions for the use of automated dispensing devices will improve access and utilization but will also ensure that drugs with older expiration dates are not left indefinitely mixed with drugs that have newer expiration dates. These requirements are intended to ensure the safety and efficacy of prescription drugs dispensed in this manner.

There are no disadvantages to the public; it should benefit from increased efficiencies, use of technology, improved access, and efforts to ensure minimal competency of pharmacists to practice.

The primary advantages and disadvantages to the agency or the Commonwealth: The primary advantages to the agency (Board of Pharmacy) are: (i) clarification of rules that have generated questions to board staff from applicants and licensees and (ii) a reduction in cost for annually providing hard copy of updated laws and regulations to all licensees. In 2002, the estimated cost for mailing the law packet was \$10,000. To reduce the cost, each pharmacy was provided a CD instead. Amended regulations will eliminate the requirement to have a copy in each pharmacy, since the

information is readily available electronically or may be obtained by requesting a copy from the board office.

Department of Planning and Budget's Economic Impact Analysis: The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with § 2.2-4007 H of the Administrative Process Act and Executive Order Number 21 (02). Section 2.2-4007 H requires that such economic impact analyses include, but need not be limited to, the projected number of businesses or other entities to whom the regulation would apply, the identity of any localities and types of businesses or other entities particularly affected, the projected number of persons and employment positions to be affected, the projected costs to affected businesses or entities to implement or comply with the regulation, and the impact on the use and value of private property. The analysis presented below represents DPB's best estimate of these economic impacts.

Summary of the proposed regulation. The Board of Pharmacy (board) proposes numerous amendments to these regulations, including: (i) lengthening the period after pharmacist licensure renewal due dates by which a licensee may pay a late fee in lieu of reinstatement, (ii) changing the required fees for licensure reinstatement, (iii) introducing the re-inspection process and a re-inspection fee for pharmacy permits, (iv) eliminating the requirement that applicants for examination file affidavits or certificates of experience with the board no less than 30 days prior to the date of the examination, (v) for those seeking reinstatement, capping the number of required hours continuing education at 60 hours, (vi) for those whose licenses have been suspended, lapsed or inactive for more than five years, requiring passage of the board-approved law examination and documentation of either active practice in another state or practical experience of at least 160 hours within the past six months as a pharmacy intern, (vii) eliminating the requirement that pharmacists maintain continuing education documentation at their principal place of practice, (viii) allowing a pharmacist to serve as pharmacist-in-charge (PIC) at two pharmacies rather than just one, (ix) specifying that a PIC who is absent from practice for more than 30 consecutive days is deemed to no longer be the PIC, (x) allowing extensions to the 14-day deadline to obtain a replacement PIC, (xi) eliminating requirements that certain equipment and resources be kept if unnecessary for pharmacy's practice, (xii) permitting pharmacy technicians to enter the prescription department in the absence of a licensed pharmacist under certain conditions, (xiii) allowing off-site storage of certain required records, (xiv) allowing an electronic image of a prescription to be maintained in an electronic database in lieu of a hard copy file for Schedule VI prescriptions, (xv) allowing an electronic image of a prescription to be maintained in an electronic database in lieu of a hard copy file for Schedule II-V prescriptions if permitted by federal law, (xvi) allowing prescriptions to be faxed from a long term care facility or a hospice, (xvii) eliminating certain pharmaceutical labeling requirements for drugs dispensed to patients of a hospital or long term care facility where all drugs are administered by persons licensed to administer, (xviii) eliminating the requirement that a signed release be obtained when non-special (non-child resistance) packaging is requested, (xix) allowing transfer between two pharmacies of a prescription whether it has been filled or not, (xx) when

authorized by the PIC, permitting nurses other than the supervisory nurse to have access to the pharmacy in the absence of the pharmacist in order to obtain emergency medication, (xxi) allow receipts of floor stock drugs and the records that are used to document administration of Schedule II through V drugs to be maintained by the hospital pharmacy in offsite storage, (xxii) permitting audits of the distribution and administration of drugs from automated dispensers to cover a sample of records, rather than all records, (xxiii) expanding the permitted use of automated dispensing devices in nursing homes, (xxiv) permitting certain cost-saving measures by correctional institutions, and (xxv) allowing medical equipment suppliers to keep original orders on file at a centralized office.

Estimated economic impact. License renewal, late fees, and reinstatement. Currently, a pharmacist who fails to renew his license on or before its expiration date, may renew the license if he pays a \$30 late fee and the \$90 annual renewal fee within 60 days after the expiration date. After the 60 days, the licensee must apply for reinstatement, pay a \$70 delinquent fee, demonstrate compliance with continuing education (CE) requirements, and pay all back renewal fees.

The proposed regulations allow licensees one year from the expiration date to renew a late license. During that year the license may simply pay the \$30 late fee in addition to the \$90 renewal fee. Thus, those individuals who seek to renew their license from 31 days after its expiration to one year after its expiration save \$40 in fees and the time and effort it takes to apply for reinstatement.

After the one year, the licensee must apply for reinstatement, pay a \$210 reinstatement fee, pay the current \$90 renewal fee, demonstrate compliance with continuing education requirements, and pay the current \$90 renewal fee, but is not required to pay all back renewal fees. An individual who seeks to reinstate two years after expiration will be \$40 better off under the proposed regulations.¹ An individual who seeks to reinstate three years after expiration will be \$130 better off under the proposed regulations.² An individual who seeks to reinstate four years after expiration will be \$220 better off under the proposed regulations.³ Thus, for individuals who seek to renew or reinstate their license four or fewer years after its expiration, the proposed regulations offer lower costs than the current regulations.

The current regulations have been interpreted as meaning that individuals must document having taken 15 hours of CE for each year that the license has not been active or current. The proposed regulations cap the number of required hours at 60. For individuals whose license has been inactive or non-current four years or less, this change will have no impact.

¹ Fees for reinstatement after two years under the current regulations: (\$90 current fee) + (\$180 in back fees) + (\$70 delinquent fee) = \$340. Fees for reinstatement after two years under the proposed regulations: (\$90 current fee) + (\$210 reinstatement fee) = \$300.

² Fees for reinstatement after three years under the current regulations: (\$90 current fee) + (\$270 in back fees) + (\$70 delinquent fee) = \$430. Fees for reinstatement after three years under the proposed regulations: (\$90 current fee) + (\$210 reinstatement fee) = \$300.

³ Fees for reinstatement after four years under the current regulations: (\$90 current fee) + (\$360 in back fees) + (\$70 delinquent fee) = \$520. Fees for reinstatement after four years under the proposed regulations: (\$90 current fee) + (\$210 reinstatement fee) = \$300.

For those whose license has been inactive or non-current for more than four years, the cap will reduce cost.⁴ For example, someone who seeks to reactivate or reinstate their license after five or six years will only need to complete 60 hours of continuing education versus 75 or 90 hours⁵ under the current regulations. There is no evidence concerning the marginal effectiveness of 75 or 90 hours of continuing education relative to 60 hours of continuing education. Due to this uncertainty, not reliable conclusion may be drawn concerning the net economic impact of the change although we do know that, for those few seeking reinstatement of a long-lapsed license, the proposed change will certainly reduce compliance costs. An individual who seeks to reinstate five years after expiration will be more than \$310 better off under the proposed regulations.⁶

Though the board proposes to reduce the CE burden for applicants whose license has been inactive or non-current for more than four years, the board also proposes to introduce new requirements for those whose license has been inactive or non-current for more than five years. A pharmacist who has allowed his Virginia license to lapse for more than five years and is unable to document active practice in another jurisdiction will be required to serve a 160-hour internship under the supervision of a pharmacist with current licensure. Since staff pharmacists earn approximately \$40/hour, while pharmacy technicians and interns earn approximately \$12/hour,⁷ this proposed requirement may cost affected pharmacists as much as \$4,480.⁸ According to the department, changes in pharmacy practice and pharmaceuticals occur frequently, and five or more years away from pharmacy work leaves pharmacists unable to practice safely without supervision.

One month's work (160 hours) under the supervision of an active pharmacist will likely enable a pharmacist to become significantly more current in his knowledge of changes to pharmacy practice over his time away from active work. Information is not available, though, to determine the amount by which the risk of potential mistakes is diminished by requiring the internship. Since this information is not available, it cannot be determined whether the cost imposed on the applicant exceeds the benefit of a potential reduced risk of mistakes by the pharmacist returning to practice.

The board also proposes to require those pharmacists whose license has been inactive or non-current for more than five years to pass a board-approved law examination at a cost of \$200. Though federal and state laws concerning drugs and pharmacy practice can change significantly over five or more

⁴ According to the Department of Health Professions, costs for continuing education courses can range from \$10 for an on-line course to several hundred dollars for a live seminar. Applicants' time also has value. Since applicants in this situation are not currently able to practice, the value of their time is likely best judged at a figure somewhat less than hourly rate earned by licensed pharmacists (\$40 an hour).

⁵ Calculation: (15 CE hours per year) x 6 = 90 CE hours

⁶ Fees for reinstatement after five years under the current regulations: (\$90 current fee) + (\$450 in back fees) + (\$70 delinquent fee) = \$610. Fees for reinstatement after five years under the proposed regulations: (\$90 current fee) + (\$210 reinstatement fee) = \$300. In addition, the proposed regulations require 15 fewer hours of CE.

⁷ Source: Department of Health Professions

⁸ [(\$40 per hour) - (\$12 per hour)] x 160 hours = \$4,480

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years, it is not clear that the benefits of requiring applicants to pass a legal examination exceed or equal \$200 per individual. Given the required 160-hour internship for such individuals, it is likely that they will learn about the important changes in law in recent years through their 160-hour internship. Plus, the PIC will have the incentive to ensure that a returning pharmacist is caught up as well due to their responsibility concerning pharmacy operations. An individual who seeks to reinstate six years after expiration will be financially worse off under the under the proposed regulations.⁹

Practical experience. Some states do not require as many hours of practical experience in an internship as Virginia does for licensure, or do not maintain complete records; so an applicant for licensure by endorsement in Virginia who may have already been practicing in another state may be required to first work in an internship in the Commonwealth in order to practice. Practically, this potentially discourages some highly skilled and experienced out-of-state pharmacists from seeking to practice in Virginia. Interns earn much lower pay than independent pharmacists (\$12 per hour versus \$40 per hour);¹⁰ and even if the pay was comparable, it is unlikely that many pharmacists would be tempted to leave an out-of-state position as an independent pharmacist to work as someone else's intern in Virginia. Discouraging out-of-state pharmacists from seeking licensure in Virginia this way reduces the potential number of working pharmacists in the Commonwealth. This reduces the amount of pharmacy services that can be made available to Virginians.

The board proposes to accept verification of practical experience hours worked as a pharmacist in other states in lieu of intern hours in order to meet Virginia's practical experience requirement for licensure. This will effectively remove the above-mentioned disincentive for out-of-state pharmacists to seek licensure by endorsement. Potentially, more pharmacies may open or existing pharmacies may be open for longer hours due to greater availability of licensed pharmacists in Virginia. An increased supply of pharmacists may lower the market wage for pharmacists in the Commonwealth. If there are more available to choose from, pharmacy owners may not have to offer as high a wage in order to find pharmacists to accept job offers.

A requirement for an applicant for examination to file affidavits or certificates of experience with the board no less than 30 days prior to the date of the examination was deleted as unnecessary. When the regulation was first enacted, the examination was only given three times a year. This requirement ensured that the board would have time to verify the documents in time for the candidate to sit for the examination. Now examinations are given via computer and can be scheduled immediately once the application is

approved. This proposal eliminates an unnecessary cost for applicants.

Record keeping. The board has proposed several amendments that will reduce record-keeping costs by allowing off-site storage. Pharmacists will no longer be required to maintain CE documentation at their "principal place of practice," since CE is no longer audited as part of the pharmacy inspection. Random audits are conducted by the agency, and licensees are required to send in documentation upon a request from the board.

In addition, another proposed amendment will allow off-site storage of certain required records, such as invoices, if allowed by the U.S. Drug Enforcement Administration (DEA), provided the records are readily retrievable for inspection when requested. This change has been frequently requested by Virginia pharmacies.¹¹ DEA does not allow for off-site storage of certain records, but will, upon request, allow others to be stored at an off-site location.¹²

Further proposed amendments will allow receipts of floor stock drugs and the records that are used to document administration of Schedule II through V drugs to be maintained by hospital pharmacies in offsite storage provided they are retrievable and can be made available for inspection or audit within 48 hours of a request by the board or an authorized agent. This provision will alleviate the need to retain the receipts at the hospital, where storage is often a problem.

The ability to store certain records in off-site storage will likely provide a significant benefit to pharmacies that are now required to utilize valuable in-house space for such use. This proposed amendment allows pharmacies and medical equipment suppliers to utilize on-site storage space for other purposes, and in some cases potentially expand their operations.

Pharmacist-in-charge. The Code of Virginia requires the pharmacist-in-charge (PIC) to be "fully engaged" in the practice of pharmacy at that location. Under the current regulations a pharmacist may only be PIC of one pharmacy. The board proposes to allow a pharmacist to serve as PIC at two pharmacies. The board determined that a pharmacist, for example, working full time for a chain pharmacy, could work an average of 20 hours one week at one pharmacy, and 20 hours the same week at a second pharmacy and still be "fully engaged" at both locations, have full knowledge of pharmacy practice at that site, and be able to control the practice (including inventory issues) at both locations. Allowing individuals to be PIC at a second pharmacy allows pharmacy owners additional flexibility in hiring and management decisions. In particular, it may allow additional pharmacy locations to be established, since, according to the department, there is a shortage in the Commonwealth of individuals with the skills and desire to work as a PIC. Also, for example, an owner of two pharmacies may judge that one of his PICs is significantly more talented than the other, and

⁹ Fees for reinstatement after six years under the current regulations: (\$90 current fee) + (\$540 in back fees) + (\$70 delinquent fee) + (the cost of 90 hours of CE) = \$700 + (the cost of 90 hours of CE). Fees for reinstatement after six years under the proposed regulations: (\$90 current fee) + (\$210 reinstatement fee) + (\$4,480 for 160 hours as intern rather than pharmacist) + (\$200 for the legal exam) + (the cost of 60 hours of CE) = \$4,980 + (the cost of 60 hours of CE). As long as the value of 30 hours of CE is less than \$4,280 (\$4,980 - \$700), then the individual is financially worse off under the proposed regulations.

¹⁰ Source: Department of Health Professions

¹¹ Ibid

¹² Ibid

the two pharmacies would be better managed with the better PIC as PIC of both.

Re-inspection. Under the current regulations if a pharmacy applicant fails their site inspection, but successfully completes all other aspects of their permit application, the applicant must still submit a new permit application with a \$270 fee and wait 14 days to reschedule an inspection. The board proposes to amend the regulations to allow the pharmacy to schedule a re-inspection without resubmitting a full permit application. The re-inspection fee is set at \$150. This will save the time and cost of redoing the initial part of the application process for both the pharmacy and the department. In addition to saving \$120 in fees, the pharmacy will likely be able to be re-inspected sooner, potentially permitting it to begin operations and earning revenue sooner. This amendment produces a net benefit since there is no downside to the change in procedure.

Required minimum equipment or resources. The current regulations require that all pharmacies maintain a set of prescription balances and weights or an electronic scale, a general dispensing information reference that may contain the entire scope of pharmaceuticals, and a copy of the current Virginia Drug Control Act and board regulations. Under the proposed regulations, a set of prescription balances and weights or an electronic scale will only be required if the pharmacy engages in dispensing activities that require the weighing of components; and pharmacies only have to keep present a reference consistent with the scope of pharmacy practice at the location of the permitted pharmacy. Also, pharmacies will no longer be required to possess a copy of the current Virginia Drug Control Act and board regulations. Pharmacies that have no business need for a set of prescription balances and weights or an electronic scale will save on purchasing those items, or may sell them if they are already present. The department estimates that balances and weights or an electronic scale used for pharmacy sell for between \$700 to \$1200. Amending the requirements for the pharmacy to maintain a copy of pharmacy laws and regulations will result in a cost saving to the board and hence to licensees. The most recent estimate for copying and mailing to all pharmacies was approximately \$10,000. Those and other pharmacy resources are readily available and retrievable through the Internet at no cost.

Access to prescription department. Current regulations do not allow anyone to enter the prescription department in the absence of a licensed pharmacist. Pharmacies have occasionally had problems with a patient needing to pick up a prescription that has already been filled, reviewed and certified for accuracy by a pharmacist. This problem occurs when a pharmacist is unexpectedly not available during regular business hours, for example, if the pharmacist had to leave unexpectedly due to an emergency, or if the pharmacist scheduled to open the prescription department in the morning is ill and cannot make it to open. There are likely prescriptions that have already been filled and checked but not yet picked up by the patient. For example, a patient calls in a refill request on a given day and it is filled that day, but when he comes to pick it up the next morning during regular pharmacy hours, there is no pharmacist there due to an unexpected event.

To alleviate the problem, the board has established conditions under which a pharmacy technician, with permission of a pharmacist employed at that pharmacy, could disable the alarm and enter the pharmacy accompanied by management to retrieve the already filled prescriptions. That entry would have to be fully documented, and the access code changed by the PIC after such an event. This proposed change produces a net benefit. Patients may experience serious negative health outcomes if there is a delay in their receipt and use of their prescribed pharmaceuticals. Permitting pharmacy technicians to retrieve previously reviewed and certified prescriptions when the pharmacist is unexpectedly not available, reduces the likelihood that patients will experience negative health outcomes due to delay in treatment. The conditions under which the drugs can be retrieved do not significantly increase the chance that mistaken prescriptions are distributed.

Under the current regulations, only a supervisory nurse may have access to a hospital pharmacy in the absence of the pharmacist in order to obtain emergency medication. The board proposes to permit nurses other than the supervisory nurse to have access to the pharmacy in the absence of the pharmacist in order to obtain emergency medication, if previously authorized by the PIC. This will also reduce the likelihood that patients will experience negative health outcomes due to a delay in treatment.

Electronic data in lieu of hard copy. The board proposes to allow an electronic image of a prescription to be maintained in an electronic database in lieu of a hard copy file for Schedule VI prescriptions, provided it preserves and provides an exact image of the prescription that is clearly legible and made available within 48 hours. DEA does not currently allow electronic data to be maintained in lieu of hard copies for Schedule II - V prescriptions, but proposed language would allow this if the federal rules are amended. This proposal has the potential to produce significant savings for pharmacies since the cost of scanning equipment can be offset and exceeded by the savings that result from not having to file and store thousands of hard copy prescriptions. Valuable physical space would be replaced by electronic storage at a cost saving to the pharmacy.

Labeling and packaging. Current labeling requirements provide that if a generic drug is dispensed when a prescription is written for a brand name drug, the label must contain the generic name followed by the words "generic for" followed by the brand name of the drug prescribed. The purpose for this requirement is to ensure that patients do not mistakenly self-administer double doses, by taking one dose from the name brand bottle and another dose from the generic name bottle.¹³ A proposed amendment will eliminate this requirement for drugs dispensed to patients of a hospital or long term care facility where all drugs are administered by persons licensed to administer. This will result in some savings in the time and cost of producing the extra information on the prescription. Persons licensed to administer are less likely to not recognize that a generic prescription is actually the same medication as a brand name, but they are not immune from this mistake. It

¹³ Ibid

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is unclear whether the cost savings of not adding the extra information exceeds the increased risk of accidental double doses.

If nonspecial packaging is requested (non-child resistance), federal law only requires a notation on a record that such a request was made by the patient or the patient's agent. State statute only requires that a request be made in order to dispense in non-child-resistant packaging. Current regulations require a signed release. The board proposes an amendment that will allow a notation on a patient's electronic record of a request for non-special packaging in lieu of a signed release. This will relieve pharmacies of the cost of securing and maintaining hard copies of a signed release from the patient.

Prescription transfer between pharmacies. Proposed amendments will permit the transfer of prescriptions from pharmacy to pharmacy prior to the filling of the prescription. For an example of where this is relevant, there are firms that have long-term contracts to deliver drugs to institutions by mail order. On occasion, mail order firms may know that they will not be able to make certain deliveries on time. In these circumstances, the unfilled prescription could be transferred to a local pharmacy. Thus, this proposed amendment will allow for the timely delivery of prescriptions that otherwise would not occur. This may prevent significant negative health outcomes due to the delay in receipt and use of drugs by patients.

Automated dispensing devices. The board proposes to permit audits of the distribution and administration of drugs from automated dispensers to cover a sample of records, rather than all records as currently required. Audits of all records is considered redundant due to other requirements such as complete reviews of the discrepancy report, full checks that all drugs removed from the pharmacy were actually loaded into the device, random checks to ensure that valid orders exist, and checks of at least one day's administration records from each device for each month. These checks are judged to be at least as effective at detecting errors and intentionally diverted drugs as the required procedures for manual floor stock systems. Using audits covering samples rather than all records will save time and labor costs for pharmacies.

Correctional institutions. The board proposes to permit: (i) correctional facilities to return unused or discontinued drugs to the provider pharmacy or to a secondary pharmacy within 30 days, (ii) a pharmacist from the correctional facility to forward drugs to a returns company, and (iii) drugs to be stocked at a medical clinic or surgery center that is part of the correctional facility and is staffed by one or more physicians, providing the clinic applies for and receives a controlled substance registration. All of these proposed amendments will allow correctional facilities to reduce the cost of their pharmacy operations.

Businesses and entities affected. The proposed amendments affect the 7,655 actively licensed pharmacists, 888 pharmacists with inactive licenses, the 1,597 permitted pharmacies, their clients, health care facilities, medical equipment suppliers, and correctional institutions in the Commonwealth.

Localities particularly affected. The proposed regulations affect all Virginia localities. Amendments permitting

pharmacists to serve as PIC at two locations and that lower the cost for out-of-state or recently inactive pharmacists to begin or resume practicing in Virginia may particularly affect rural parts of the Commonwealth by providing making additional pharmacist labor services available there.

Projected impact on employment. Amendments that lower the cost for out-of-state or recently inactive pharmacists to begin or resume practicing in Virginia may increase the number of individuals who seek to actively practice in Virginia.

Effects on the use and value of private property. Amendments permitting pharmacists to serve as PIC at two locations and that lower the cost for out-of-state or recently inactive pharmacists to begin or resume practicing in Virginia may result in additional pharmacy services being offered in Virginia. The introduction of the re-inspection fee and process may allow new or moved pharmacies to open or re-open earlier. Several proposals will permit pharmacies to store paperwork and data offsite or electronically, allowing space at the pharmacy to be used for other purposes. Pharmacies that do not need balances and weights or an electronic scale will no longer be required purchase or maintain them.

Agency's Response to the Department of Planning and Budget's Economic Impact Analysis: The Board of Pharmacy generally concurs with the analysis of the Department of Planning and Budget (DPB) for amendments to 18 VAC 110-20 as recommended during a periodic review of regulations.

However, there are several statements that need further explanation as follows:

Renewal and reinstatement. In the discussion of a required 160-hour internship for pharmacists who have a lapsed Virginia license and have not been actively practicing elsewhere, there is a statement that the pharmacist would likely be paid as a technician during the internship and therefore would lose as much as \$4,480. In reality, the current market for pharmacists is so competitive, it is more likely that the pharmacist would be paid a signing bonus and his full salary while he is serving the 160-hour internship. The pharmacy would ensure that he works along with another licensed pharmacist to oversee his work, but he would not be employed or paid as an intern or technician.

DPB further concludes that it is likely that the pharmacist who is serving the internship would likely learn about the changes in pharmacy law and regulation in recent years through instruction by the supervising pharmacist or PIC. The board would take exception to such a presumption. First, the opportunities to learn state and federal laws do not always present themselves in a typical work environment; and second, it is incorrect to presume that all licensed pharmacists in Virginia are themselves current with changes in pharmacy law that occur on a regular basis. The only mechanism offering some assurance of knowledge of federal and state law is passage of the jurisprudence exam.

Practical experience: It is presumed that the problems described in the first paragraph of this section are directed to current regulation, while the second paragraph explains the benefit of the proposed regulation. The board would prefer that there be a more clear distinction.

Labeling and packaging: In analyzing the proposed change to labeling requirements for hospitals and long term care facilities, DPB has concluded that it is not clear whether the cost savings of not adding the extra information exceeds the increased risk of accidental double doses. The board would disagree that the change has the potential to increase the risk of double doses in any case. In both settings, there is a single provider or hospital pharmacy that is not going to dispense the same drug (generic and brand) to the same patient based on an order from a physician. The situations necessitating labeling with both names simply do not exist in those settings, so the current requirement places an unnecessary burden on those pharmacies that does not contribute to patient safety.

Summary:

The proposed amendments (i) lengthen the period after pharmacist licensure renewal due dates by which a licensee may pay a late fee in lieu of reinstatement, (ii) change the required fees for licensure reinstatement, (iii) introduce the reinspection process and a reinspection fee for pharmacy permits, (iv) eliminate the requirement that applicants for examination file affidavits or certificates of experience with the board no less than 30 days prior to the date of the examination, (v) for those seeking reinstatement, cap the number of required continuing education hours at 60 hours, (vi) for those whose licenses have been suspended, lapsed or inactive for more than five years, require passage of the board-approved law examination and documentation of either active practice in another state or practical experience of at least 160 hours within the past six months as a pharmacy intern, (vii) eliminate the requirement that pharmacists maintain continuing education documentation at their principal place of practice, (viii) allow a pharmacist to serve as pharmacist-in-charge (PIC) at two pharmacies rather than just one, (ix) specify that a PIC who is absent from practice for more than 30 consecutive days is deemed to no longer be the PIC, (x) allow extensions to the 14-day deadline to obtain a replacement PIC, (xi) eliminate requirements that certain equipment and resources be kept if unnecessary for pharmacy's practice, (xii) permit pharmacy technicians to enter the prescription department in the absence of a licensed pharmacist under certain conditions, (xiii) allow off-site storage of certain required records, (xiv) allow an electronic image of a prescription to be maintained in an electronic database in lieu of a hard copy file for Schedule VI prescriptions, (xv) allow an electronic image of a prescription to be maintained in an electronic database in lieu of a hard copy file for Schedule II-V prescriptions if permitted by federal law, (xvi) allow prescriptions to be faxed from a long-term care facility or a hospice, (xvii) eliminate certain pharmaceutical labeling requirements for drugs dispensed to patients of a hospital or long-term care facility where all drugs are administered by persons licensed to administer, (xviii) eliminate the requirement that a signed release be obtained when nonspecial (nonchild resistance) packaging is requested, (xix) allow transfer between two pharmacies of a prescription whether it has been filled or not, (xx) when authorized by the PIC, permit nurses other than the supervisory nurse to have access to the pharmacy in the absence of the pharmacist in order to obtain emergency medication, (xxi) allow receipts of floor stock drugs and the

records that are used to document administration of Schedule II through V drugs to be maintained by the hospital pharmacy in offsite storage, (xxii) permit audits of the distribution and administration of drugs from automated dispensers to cover a sample of records, rather than all records, (xxiii) expand the permitted use of automated dispensing devices in nursing homes, (xxiv) permit certain cost-saving measures by correctional institutions, and (xxv) allow medical equipment suppliers to keep original orders on file at a centralized office.

18 VAC 110-20-10. Definitions.

In addition to words and terms defined in §§ 54.1-3300 and 54.1-3401 of the Code of Virginia, the following words and terms when used in this chapter shall have the following meanings, unless the context clearly indicates otherwise:

"ACPE" means the American Council on Pharmaceutical Education.

"Acquisition" of an existing entity permitted, registered or licensed by the board means (i) the purchase or transfer of all or substantially all of the assets of the entity or of any corporation that owns or controls the entity; (ii) the creation of a partnership by a sole proprietor or change in partnership composition; (iii) the acquiring of 50% or more of the outstanding shares of voting stock of a corporation owning the entity or of the parent corporation of a wholly owned subsidiary owning the entity, except that this shall not apply to any corporation the voting stock of which is actively traded on any securities exchange or in any over-the-counter market; or (iv) the merger of a corporation owning the entity, or of the parent corporation of a wholly owned subsidiary owning the entity, with another business or corporation.

"Aseptic processing" means the technique involving procedures designed to preclude contamination of drugs, packaging, equipment, or supplies by microorganisms during processing.

"Beyond-use date" means the date beyond which the integrity of a compounded, repackaged, or dispensed drug can no longer be assured and as such is deemed to be adulterated or misbranded as defined in §§ 54.1-3461 and 54.1-3462 of the Code of Virginia.

"Board" means the Virginia Board of Pharmacy.

"CE" means continuing education as required for renewal of licensure by the Board of Pharmacy.

"CEU" means a continuing education unit awarded for credit as the equivalent of 10 contact hours.

"Class 100 environment" means an atmospheric environment which contains less than 100 particles, 0.5 microns in diameter, per cubic foot of air.

"Closed system transfer" means the movement of sterile products from one container to another in which the container-closure system and transfer devices remain intact throughout the entire transfer process, compromised only by the penetration of a sterile, pyrogen-free needle or cannula through a designated stopper or port to effect transfer,

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withdrawal, or delivery, to include the withdrawal of a sterile solution from an ampul in a class 100 environment.

"Compliance packaging" means packaging for dispensed drugs which is comprised of a series of containers for solid oral dosage forms and which is designed to assist the user in administering or self-administering the drugs in accordance with directions for use.

"Contact hour" means the amount of credit awarded for 60 minutes of participation in and successful completion of a continuing education program.

"Cytotoxic drug" means a drug which has the capability of killing living cells.

"DEA" means the United States Drug Enforcement Administration.

"Electronic transmission prescription" is any prescription, other than an oral or written prescription or a prescription transmitted by facsimile machine, that is electronically transmitted from a practitioner authorized to prescribe directly to a pharmacy without interception or intervention from a third party, or from one pharmacy to another pharmacy.

"Expiration date" means that date placed on a drug package by the manufacturer or repacker beyond which the product may not be dispensed or used.

"Facsimile (FAX) prescription" means a written prescription or order which is transmitted by an electronic device over telephone lines which sends the exact image to the receiver (pharmacy) in a hard copy form.

"FDA" means the United States Food and Drug Administration.

"Floor stock" means a supply of drugs which have been distributed for the purpose of general administration by a prescriber or other authorized person pursuant to a valid order of a prescriber.

"Foreign school of pharmacy" means a school outside the United States and its territories offering a course of study in basic sciences, pharmacology, and pharmacy of at least four years in duration resulting in a degree that qualifies a person to practice pharmacy in that country.

"Generic drug name" means the nonproprietary name listed in the United States Pharmacopeia-National Formulary (USP-NF) or in the USAN and the USP Dictionary of Drug Names.

"Hermetic container" means a container that is impervious to air or any other gas under the ordinary or customary conditions of handling, shipment, storage, and distribution.

"Home infusion pharmacy" means a pharmacy which compounds solutions for direct parenteral administration to a patient in a private residence, long-term care facility or hospice setting.

"Hospital" or "nursing home" means those facilities as defined in Title 32.1 of the Code of Virginia or as defined in regulations by the Virginia Department of Health.

"Inactive license" means a license which is registered with the Commonwealth but does not entitle the licensee to practice,

the holder of which is not required to submit documentation of CE necessary to hold an active license.

"Light-resistant container" means a container that protects the contents from the effects of light by virtue of the specific properties of the material of which it is composed, including any coating applied to it. Alternatively, a clear and colorless or a translucent container may be made light resistant by means of an opaque covering, in which case the label of the container bears a statement that the opaque covering is needed until the contents have been used. Where a monograph directs protection from light, storage in a light-resistant container is intended.

"Long-term care facility" means a nursing home, retirement care, mental care or other facility or institution which provides extended health care to resident patients.

"Nuclear pharmacy" means a pharmacy providing radiopharmaceutical services.

"On-duty" means that a pharmacist is on the premises at the address of the permitted pharmacy and is available as needed.

"Open-system transfer" means the combining of products in a nonsealed reservoir before filling or when a solution passes through the atmosphere during a transfer operation.

"Permitted physician" means a physician who is licensed pursuant to § 54.1-3304 of the Code of Virginia to dispense drugs to persons to whom or for whom pharmacy services are not reasonably available.

"Personal supervision" means the pharmacist must be physically present and render direct, personal control over the entire service being rendered or act being performed. Neither prior nor future instructions shall be sufficient nor, shall supervision rendered by telephone, written instructions, or by any mechanical or electronic methods be sufficient.

"Pharmacy closing" means that the permitted pharmacy ceases pharmacy services or fails to provide for continuity of pharmacy services or lawful access to patient prescription records or other required patient records for the purpose of continued pharmacy services to patients.

"PIC" means the pharmacist-in-charge of a permitted pharmacy.

"Practice location" means any location in which a prescriber evaluates or treats a patient.

"Prescription department" means any contiguous or noncontiguous areas used for the compounding, dispensing and storage of all Schedule II through VI drugs and devices and any Schedule I investigational drugs.

"PTCB" means the Pharmacy Technician Certification Board, co-founded by the American Pharmaceutical Association and the American Society of Health System Pharmacists, as the national organization for voluntary examination and certification of pharmacy technicians.

"Quality assurance plan" means a plan approved by the board for continuous monitoring, measuring, evaluating, and, if

necessary, improving the performance of a pharmacy function or system.

"Radiopharmaceutical" means any drug that exhibits spontaneous disintegration of unstable nuclei with the emission of nuclear particles or photons and includes any nonradioactive reagent kit or radionuclide generator that is intended to be used in the preparation of any such substance, but does not include drugs such as carbon-containing compounds or potassium-containing salts that include trace quantities of naturally occurring radionuclides. The term also includes any biological product that is labeled with a radionuclide or intended solely to be labeled with a radionuclide.

"Repackaged drug" means any drug removed from the manufacturer's original package and placed in different packaging.

"Robotic pharmacy system" means a mechanical system controlled by a computer that performs operations or activities relative to the storage, packaging, labeling, dispensing, or distribution of medications, and collects, controls, and maintains all transaction information.

"Safety closure container" means a container which meets the requirements of the federal Poison Prevention Packaging Act of 1970 (15 USC §§1471-1476), i.e., in testing such containers, that 85% of a test group of 200 children of ages 41-52 months are unable to open the container in a five-minute period and that 80% fail in another five minutes after a demonstration of how to open it and that 90% of a test group of 100 adults must be able to open and close the container.

"Satellite pharmacy" means a pharmacy which is noncontiguous to the centrally permitted pharmacy of a hospital but at the location designated on the pharmacy permit.

"Special packaging" means packaging that is designed or constructed to be significantly difficult for children under five years of age to open to obtain a toxic or harmful amount of the drug contained therein within a reasonable time and not difficult for normal adults to use properly, but does not mean packaging which all such children cannot open or obtain a toxic or harmful amount within a reasonable time.

"Special use permit" means a permit issued to conduct a pharmacy of a special scope of service that varies in any way from the provisions of any board regulation.

"Sterile pharmaceutical product" means a dosage form free from living microorganisms.

"Storage temperature" means those specific directions stated in some monographs with respect to the temperatures at which pharmaceutical articles shall be stored, where it is considered that storage at a lower or higher temperature may produce undesirable results. The conditions are defined by the following terms:

1. "Cold" means any temperature not exceeding 8°C (46°F). A refrigerator is a cold place in which temperature is maintained thermostatically between 2° and 8°C (36° and 46°F). A freezer is a cold place in which the temperature is

maintained thermostatically between -20° and -10°C (-4° and 14°F).

2. "Room temperature" means the temperature prevailing in a working area.

3. "Controlled room temperature" is a temperature maintained thermostatically that encompasses the usual and customary working environment of 20° to 25°C (68° to 77°F); that results in a mean kinetic temperature calculated to be not more than 25°C; and that allows for excursions between 15° and 30°C (59° and 86°F) that are experienced in pharmacies, hospitals, and warehouses.

4. "Warm" means any temperature between 30° and 40°C (86° and 104°F).

5. "Excessive heat" means any temperature above 40°C (104°F).

6. "Protection from freezing" means where, in addition to the risk of breakage of the container, freezing subjects a product to loss of strength or potency, or to the destructive alteration of its characteristics, the container label bears an appropriate instruction to protect the product from freezing.

7. "Cool" means any temperature between 8° and 15°C (46° and 59°F).

"Terminally ill" means a patient with a terminal condition as defined in § 54.1-2982 of the Code of Virginia.

"Tight container" means a container that protects the contents from contamination by extraneous liquids, solids, or vapors, from loss of the drug, and from efflorescence, deliquescence, or evaporation under the ordinary or customary conditions of handling, shipment, storage, and distribution, and is capable of tight reclosure. Where a tight container is specified, it may be replaced by a hermetic container for a single dose of a drug and physical tests to determine whether standards are met shall be as currently specified in United States Pharmacopeia-National Formulary.

"Unit dose container" means a container that is a single-unit container, as defined in United States Pharmacopeia-National Formulary, for articles intended for administration by other than the parenteral route as a single dose, direct from the container.

"Unit dose package" means a container that contains a particular dose ordered for a patient.

"Unit dose system" means a system in which multiple drugs in unit dose packaging are dispensed in a single container, such as a medication drawer or bin, labeled only with patient name and location. Directions for administration are not provided by the pharmacy on the drug packaging or container but are obtained by the person administering directly from a prescriber's order or medication administration record.

"USP-NF" means the United States Pharmacopeia-National Formulary.

"Well-closed container" means a container that protects the contents from extraneous solids and from loss of the drug under the ordinary or customary conditions of handling, shipment, storage, and distribution.

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18 VAC 110-20-20. Fees.

A. Unless otherwise provided, fees listed in this section shall not be refundable.

B. ~~Fee for initial pharmacist licensure~~ *Unless otherwise provided, any fees for taking required examinations shall be paid directly to the examination service as specified by the board.*

~~1. The application fee for a pharmacist license shall be \$180.~~

~~2. The fees for taking all required examinations shall be paid directly to the examination service as specified by the board.~~

~~3. The application fee for a person whose license has been revoked or suspended indefinitely shall be \$500.~~

C. ~~Renewal of pharmacist license.~~

~~1. The annual fee for renewal of an active pharmacist license shall be \$90.~~

~~2. The annual fee for renewal of an inactive pharmacist license shall be \$45.~~

~~3. If a pharmacist fails to renew his license within the Commonwealth by the renewal date, he must pay the back renewal fee and a \$30 late fee within 60 days of expiration.~~

~~4. Failure to renew a pharmacist license within 60 days following expiration shall cause the license to lapse and shall require the submission of a reinstatement application, payment of all unpaid renewal fees, and a delinquent fee of \$70.~~

D. ~~Other licenses, permits or facility registrations.~~

~~1. The following fees shall be required upon submission of a new facility application, change of ownership of an existing facility, or annual renewal:~~

a. Pharmacy permit	\$270
b. Permitted physician to dispense drugs	\$270
e. Nonrestricted manufacturing permit	\$270
d. Restricted manufacturing permit	\$180
e. Wholesale distributor license	\$270
f. Warehouser permit	\$270
g. Medical equipment supplier permit	\$180
h. Licensed humane society permit	\$20
i. Nonresident pharmacy	\$270
j. Nonresident wholesale distributor	\$270

~~2. The following fees shall be required for facility changes:~~

a. Application for a change of the pharmacist in charge	\$50
b. Application for a change of location or a remodeling which requires an inspection	\$150

~~3. The following fees shall be required for late renewals or reinstatement.~~

~~a. If a facility fails to renew a required license, permit or registration prior to the expiration date, a late fee shall be assessed as follows:~~

~~(1) For a resident or nonresident pharmacy, permitted physician, nonrestricted manufacturer, resident or nonresident wholesale distributor, or warehouser, the late fee shall be \$90.~~

~~(2) For a restricted manufacturer or medical equipment supplier, the late fee shall be \$60.~~

~~b. If a required license, permit or facility registration is not renewed within 60 days after its expiration, the license or permit shall lapse, and continued practice or operation of business with a lapsed license or permit shall be illegal. Thereafter, reinstatement shall be at the discretion of the board upon submission of an application accompanied by all unpaid renewal fees and a delinquent fee of \$150.~~

E. ~~Controlled substances registration.~~

~~1. The application and annual fee for a controlled substances registration as required by § 54.1-3422 of the Code of Virginia shall be \$90.~~

~~2. If a registration is not renewed within 60 days of the expiration date, the back renewal fee and a \$30 late fee shall be paid prior to renewal.~~

~~3. If a controlled substance registration has been allowed to lapse for more than 60 days, all back renewal fees and a \$35 delinquent fee must be paid before a current registration will be issued. Engaging in activities requiring a controlled substance registration without holding a current registration is illegal and may subject the registrant to disciplinary action by the board. Reinstatement of a lapsed registration is at the discretion of the board and may be granted by the executive director of the board upon completion of an application and payment of all fees.~~

F. ~~Other fees.~~

~~1. A request for a duplicate wall certificate shall be accompanied by a fee of \$25.~~

~~2. The fee for a returned check shall be \$25.~~

~~3. The fee for board approval of an individual CE program is \$100.~~

~~4. The fee for board approval of a robotic pharmacy system shall be \$150.~~

~~5. The fee for a board required inspection of a robotic pharmacy system shall be \$150.~~

G. ~~Approval of new process or procedure in pharmacy.~~

~~1. The fee for filing an application for board review of a new process, procedure or pilot project in pharmacy pursuant to § 54.1-3407.2 of the Code of Virginia shall be \$250. The initial application shall specify each pharmacy location in which the pilot is to be implemented.~~

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~~2. The fee for an inspection of a pilot process or procedure, if required by the informal conference committee, shall be \$150 per location.~~

~~3. If the board determines that a technical consultant is required in order to make a decision on approval, any consultant fee, not to exceed the actual cost, shall be paid by the applicant.~~

~~4. The fee for a change in the name of the pharmacist responsible for the pilot program shall be \$25.~~

~~5. Continued approval-~~

~~a. In the initial order granting approval, the informal conference committee shall also set an approval period with a schedule for submission of reports and outcome data. The frequency for submission of required reports shall not exceed four times per year.~~

~~b. The committee shall determine the appropriate fee for continued approval, which shall be based on the requirements for review and monitoring but which shall not exceed \$200 per approval period.~~

~~H. Pharmacy technicians-~~

~~1. The application fee for initial registration as a pharmacy technician is \$25.~~

~~2. The application fee for a person whose registration has been suspended or revoked is \$125.~~

~~3. The annual fee for renewal of a pharmacy technician registration is \$25.~~

~~4. If a pharmacy technician fails to renew his registration within the Commonwealth by the renewal date, he must pay the back renewal fee and a \$10 late fee within 60 days of expiration.~~

~~5. Failure to renew a pharmacy technician registration within 60 days following expiration shall cause the registration to lapse and shall require the submission of a reinstatement application, payment of all unpaid renewal fees, and a delinquent fee of \$25.~~

~~6. The application fee for approval of a training program for pharmacy technicians shall be \$150.~~

~~C. Initial application fees.~~

1. Pharmacist license	\$180
2. Pharmacy intern registration	\$15
3. Pharmacy technician registration	\$25
4. Pharmacy permit	\$270
5. Permitted physician licensed to dispense drugs	\$270
6. Nonrestricted manufacturer permit	\$270
7. Restricted manufacturer permit	\$180
8. Wholesale distributor license	\$270
9. Warehouse permit	\$270

10. Medical equipment supplier permit	\$180
11. Humane society permit	\$20
12. Nonresident pharmacy	\$270
13. Nonresident wholesale distributor	\$270
14. Controlled substances registrations	\$90
15. Robotic pharmacy system approval	\$150
16. Innovative program approval	\$250

If the board determines that a technical consultant is required in order to make a decision on approval, any consultant fee, not to exceed the actual cost, shall also be paid by the applicant in addition to the application fee.

17. Approval of a pharmacy technician training program	\$150
18. Approval of a continuing education program	\$100

~~D. Annual renewal fees.~~

1. Pharmacist active license	\$90
2. Pharmacist inactive license	\$45
3. Pharmacy technician registration	\$25
4. Pharmacy permit	\$270
5. Physician permit to practice pharmacy	\$270
6. Nonrestricted manufacturer permit	\$270
7. Restricted manufacturer permit	\$180
8. Wholesale distributor license	\$270
9. Warehouse permit	\$270
10. Medical equipment supplier permit	\$180
11. Humane society permit	\$20
12. Nonresident pharmacy	\$270
13. Nonresident wholesale distributor	\$270
14. Controlled substances registrations	\$90

~~15. Innovative program continued approval based on board order not to exceed \$200 per approval period.~~

E. Late fees. The following late fees shall be paid in addition to the current renewal fee to renew an expired license within one year of the expiration date. In addition, engaging in activities requiring a license, permit, or registration after the expiration date of such license, permit, or registration shall be grounds for disciplinary action by the board.

1. Pharmacist license	\$30
2. Pharmacist inactive license	\$15
3. Pharmacy technician registration	\$10
4. Pharmacy permit	\$90
5. Physician permit to practice pharmacy	\$90

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6. Nonrestricted manufacturer permit	\$90
7. Restricted manufacturer permit	\$60
8. Wholesale distributor license	\$90
9. Warehouser permit	\$90
10. Medical equipment supplier permit	\$60
11. Humane society permit	\$5
12. Nonresident pharmacy	\$90
13. Nonresident wholesale distributor	\$90
14. Controlled substances registrations	\$30

F. Reinstatement fees. Any person or entity attempting to renew a license, permit, or registration more than one year after the expiration date shall submit an application for reinstatement with any required fees. Reinstatement is at the discretion of the board and, except for reinstatement following license revocation or suspension, may be granted by the executive director of the board upon completion of an application and payment of any required fees.

1. Pharmacist license	\$210
2. Pharmacist license after revocation or suspension	\$500
3. Pharmacy technician registration	\$35
4. Pharmacy technician registration after revocation or suspension	\$125

5. Facilities or entities that cease operation and wish to resume shall not be eligible for reinstatement but shall apply for a new permit or registration. Facilities or entities that failed to renew and continued to operate for more than one renewal cycle shall pay the current and all back renewal fees for the years in which they were operating plus the following reinstatement fees:

a. Pharmacy permit	\$240
b. Physician permit to practice pharmacy	\$240
c. Nonrestricted manufacturer permit	\$240
d. Restricted manufacturer permit	\$210
e. Wholesale distributor license	\$240
f. Warehouser permit	\$240
g. Medical equipment supplier permit	\$210
h. Humane society permit	\$30
i. Nonresident pharmacy	\$115
j. Nonresident wholesale distributor	\$115
k. Controlled substances registration	\$180

G. Application for change or inspection fees for facilities or other entities.

1. Change of pharmacist-in-charge	\$50
2. Change of ownership for any facility	\$50

3. Inspection for remodeling or change of location for any facility	\$150
4. Reinspection of any facility	\$150
5. Board-required inspection for a robotic pharmacy system	\$150
6. Board-required inspection of an innovative program location	\$150
7. Change of pharmacist responsible for an approved innovative program	\$25

H. Miscellaneous fees.

1. Duplicate wall certificate	\$25
2. Returned check	\$25

18 VAC 110-20-30. Requirements for practical experience.

A. Each applicant for licensure by examination shall have gained practical experience in the practice of pharmacy, to include no less than 300 hours in the area of prescription compounding and dispensing within a pharmacy.

B. An applicant who graduated from an approved school of pharmacy after January 1, 2003, shall accumulate a minimum of 1,500 hours of practical experience, of which at least 300 hours shall be gained outside of a school of pharmacy practical experience program. For purposes of this chapter, credit will not be given for more than 50 hours in any one week. ~~Students enrolled in a school of pharmacy prior to January 1, 1999, are required to have a minimum of 1,000 hours~~ Applicants who graduated from an approved school of pharmacy prior to January 1, 2003, shall have gained at least 1,000 hours of practical experience.

C. All practical experience credit required shall only be gained after completion of the first professional year in an approved school of pharmacy.

D. Practical experience gained in a school of pharmacy which has a program designed to provide the applicant with practical experience in all phases of pharmacy practice and which program is approved by the American Council on Pharmaceutical Education will be accepted by the board for the time period during which the student is actually enrolled. The applicant will be required to gain any additional experience outside the school program as needed to meet the requirements of subsections A and B of this section.

E. In accordance with § 54.1-3312 of the Code of Virginia, all practical experience required by this section shall be gained within the United States.

18 VAC 110-20-40. Procedure for gaining practical experience.

A. Each pharmacy student or graduate of an approved school of pharmacy who desires to gain practical experience in a pharmacy within the Commonwealth shall register with the board on a form provided by the board prior to becoming so engaged as a pharmacy intern. This requirement shall also apply to students gaining practical experience within the Commonwealth for licensure in another state.

B. The applicant shall be supervised by a pharmacist who holds an unrestricted license and assumes full responsibility for the training, supervision and conduct of the intern. The supervising pharmacist shall not supervise more than one pharmacy intern during the same time period.

C. The intern registration of a pharmacy student shall be valid only while the student is enrolled in a school of pharmacy. The registration card issued by the board shall be returned to the board upon failure to be enrolled.

D. Practical experience gained within any state must be registered with and certified by the board of that state in order to be accepted or certified by this board. *In the event that a state does not use internships to gain practical experience in pharmacy but relies on the pharmacy school to certify the hours of experience, an affidavit from the pharmacy school certifying the hours of experience gained in the United States may be accepted in lieu of board certification.*

E. All practical experience of the pharmacy intern shall be evidenced by an affidavit which shall be filed prior to or with the application for examination for licensure.

F. An applicant for ~~examination shall file affidavits or certificates of experience on a form prescribed by the board no less than 30 days prior to the date of the examination~~ *licensure by endorsement may provide verification acceptable to the board of practical experience hours worked as a pharmacist in another state within the United States in lieu of intern hours in order to meet the practical experience requirement.*

18 VAC 110-20-60. Content of the examination and grades required; limitation on admittance to examination.

A. Prior to admission to any examination required for licensure, the applicant shall have met all other requirements, but in no case shall the applicant be admitted if grounds exist to deny licensure under § 54.1-3316 of the Code of Virginia.

B. The applicant shall achieve a passing score as determined by the board on the licensure examination which is approved by the board and which shall consist of an integrated examination of pharmacy practice, pharmacology, pharmacy mathematics, and such other subjects as are necessary to assure that the candidate possesses the necessary knowledge and skills to practice pharmacy.

C. The applicant shall also achieve a passing score as determined by the board on an examination which tests the candidate's knowledge of federal and state laws related to pharmacy practice.

D. When an applicant for licensure by examination fails to meet the passing requirements of the board-approved integrated pharmacy examination on three occasions, he shall not be readmitted to the examination until he has completed an additional ~~six months~~ *1,000 hours* of practical experience as a pharmacy intern as set forth in 18 VAC 110-20-40.

18 VAC 110-20-70. Requirements for foreign-trained applicants.

A. Applicants for licensure who were trained in foreign schools of pharmacy shall meet the following *additional* requirements

prior to being allowed to take the examinations required by 18 VAC 110-20-60:

1. Obtain *verification* from the Foreign Pharmacy Graduate Examination Committee (FPGEC) of the National Association of Boards of Pharmacy (NABP) ~~verification of the following: that the applicant is a graduate of a foreign school of pharmacy.~~

~~a. That the applicant is a graduate of a foreign school of pharmacy.~~

~~b. That the applicant has received a score acceptable to the board on the Foreign Pharmacy Graduate Equivalency Examination (FPGEE).~~

~~c. That the applicant has received a score acceptable to the board on the Test of English as a Foreign Language (TOEFL).~~

2. *Complete and receive a score acceptable to the board on the Foreign Pharmacy Graduate Equivalency Examination (FPGEE).*

3. *Complete and receive a score acceptable to the board on the Test of English as a Foreign Language (TOEFL).*

~~2-~~ 4. Complete the Test of Spoken English (TSE) as given by the Educational Testing Service with a score acceptable to the board.

~~3-~~ 5. Fulfill the requirements for practical experience as prescribed in 18 VAC 110-20-30 A ~~and~~ , B ~~and~~ E ~~and all of~~ 18 VAC 110-20-40 A, B, D, E ~~and~~ F.

~~4. B. Fulfill the requirements for the examination and passing grade Applicants for licensure who were trained in foreign schools of pharmacy shall also complete and achieve passing scores on the examinations as prescribed in 18 VAC 110-20-60.~~

18 VAC 110-20-80. Renewal and reinstatement of license.

A. Pharmacist licenses expire on December 31 and shall be renewed annually prior to that date by the submission of a renewal fee, renewal form, and statement of compliance with continuing education requirements.

B. A pharmacist newly licensed on or after October 1 shall not be required to renew that license until December 31 of the following year.

C. A pharmacist who fails to renew his license by the expiration date ~~has 60 days in which to renew~~ *may renew his license at any time within one year of its expiration* by submission of the renewal fee and late fee, renewal form, and statement of compliance with continuing education requirements.

~~D. Failure to renew within the 60 days of expiration shall cause his license to lapse. A pharmacist who fails to renew his license for more than one year following expiration and who wishes to reinstate such license shall submit an application for reinstatement, pay the current renewal fee and a reinstatement fee, and submit documentation showing compliance with continuing education requirements. Reinstatement is at the discretion of the board and may be granted by the executive director of the board upon completion of an application for~~

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~~reinstatement of license, the payment of all back renewal fees and a delinquent fee, and submission of a statement of compliance with continuing education requirements. Practice of pharmacy with a lapsed license shall be illegal and may subject the licensee to disciplinary action by the board provided no grounds exist to deny said reinstatement.~~

E. A pharmacist who has been registered as inactive for more than one year must apply for reinstatement, ~~comply with CE~~ submit documentation showing compliance with continuing education requirements, and pay the current year active renewal fee in order to resume active licensure.

F. ~~In order to reactivate or reinstate a license to active status, a pharmacist who holds an inactive license, who has allowed his license to lapse, or who has had his license suspended or revoked must submit evidence of completion of CEU's or hours equal to the requirements for the number of years in which his license has not been active, not to exceed a total of 60 hours of CE.~~

G. A pharmacist whose license has been lapsed, in inactive status, or suspended or revoked for more than five years shall, as a condition of reinstatement in addition to 60 hours CE, take and receive a passing score on the board-approved law examination and furnish acceptable documentation of one of the following:

1. Active pharmacy practice within the past five years as a properly licensed pharmacist in another state; or
2. Practical experience as a pharmacy intern registered with the board of at least 160 hours within six months immediately prior to being reinstated.

H. ~~The practice of pharmacy without a current, active pharmacist license is unlawful and shall constitute grounds for disciplinary action by the board.~~

F. I. It shall be the duty and responsibility of each licensee to inform the board of his current address. A licensee shall immediately notify the board in writing of any change of an address of record. All notices required by law or by these rules and regulations are deemed to be legally given when mailed to the address given and shall not relieve the licensee of the obligation to comply.

18 VAC 110-20-90. Requirements for continuing education.

A. On and after December 31, 1993, a ~~licensee~~ pharmacist shall be required to have completed a minimum of 1.5 CEUs or 15 contact hours of continuing pharmacy education in an approved program for each annual renewal of licensure. CEUs or hours in excess of the number required for renewal may not be transferred or credited to another year.

B. A pharmacy education program approved for continuing pharmacy education is:

1. One that is approved by the American Council on Pharmaceutical Education (ACPE);
2. One that is approved as a Category I Continuing Medical Education (CME) course, the primary focus of which is pharmacy, pharmacology or drug therapy; or

3. One that is approved by the board *in accordance with the provisions of 18 VAC 110-20-100.*

C. The board may grant an extension pursuant to § 54.1-3314 E of the Code of Virginia. Any subsequent extension shall be granted only for good cause shown.

D. ~~Licensees~~ Pharmacists are required to attest to compliance with CE requirements ~~on in a manner approved by the board at the time of their annual license renewal.~~ Following the each renewal period, the board may conduct an audit of ~~licensees~~ the immediate past two years' CE documents to verify compliance with requirements. Licensees Pharmacists are required to maintain, for two years following renewal, the original certificates documenting successful completion of CE, showing date and title of the CE program or activity, the number of CEU's or contact hours awarded, and a certifying signature or other certification of the approved provider. Pharmacists selected for audit must provide these original documents certifying that they have fulfilled their CE requirements to the board by the deadline date as specified by the board in the audit notice.

E. ~~All licensees are required to maintain original documents verifying the date and subject of the program or activity, the CEUs or contact hours, and certification from an approved provider. Documentation shall be maintained for a period of two years following renewal in a file available to inspectors at the pharmacist's principal place of practice or, if there is no principal place of practice, at the pharmacist's address of record.~~

F. ~~A pharmacist who holds an inactive license, who has allowed his license to lapse or who has had his license suspended or revoked must submit evidence of completion of CEUs or hours equal to the requirements for the number of years in which his license has not been active.~~

18 VAC 110-20-105. Renewal and reinstatement of registration.

A. Pharmacy technician registrations expire on December 31 and shall be renewed annually prior to that date by the submission of a renewal fee and renewal form. A pharmacy technician newly registered on or after July 1 shall not be required to renew that registration until December 31 of the following year. Failure to receive the application for renewal shall not relieve the pharmacy technician of the responsibility for renewing the registration by the expiration date.

B. A pharmacy technician who fails to renew his registration by the expiration date ~~has 60 days in which to renew may renew his registration at any time within one year of its expiration~~ by submission of the renewal fee and late fee, renewal form, and proof of required continuing education.

C. ~~Failure to renew within the 60 days of expiration shall cause his registration to lapse. A pharmacy technician who fails to renew his registration for more than one year following expiration and who wishes to reinstate such registration shall submit an application for reinstatement, pay the current renewal fee and a reinstatement fee, and submit documentation showing compliance with continuing education requirements. Reinstatement is at the discretion of the board and may be granted by the executive director of the board~~ upon

~~completion of an application for reinstatement of registration, the payment of all back renewal fees and a delinquent fee, and submission of original continuing education certificates provided no grounds exist to deny said reinstatement.~~ Conducting tasks associated with a pharmacy technician with a lapsed registration shall be illegal and may subject the registrant to disciplinary action by the board.

D. A person who fails to reinstate a pharmacy technician registration within five years of expiration, shall not be eligible for reinstatement and shall repeat an approved training program and repeat and pass the examination, or hold current PTCB certification, before applying to be reregistered.

18 VAC 110-20-110. Pharmacy permits generally.

A. A pharmacy permit shall not be issued to a pharmacist to be simultaneously in charge of more than ~~one pharmacy~~ two pharmacies.

B. The pharmacist-in-charge (PIC) or the pharmacist on duty shall control all aspects of the practice of pharmacy. Any decision overriding such control of the ~~pharmacist-in-charge~~ PIC or other pharmacist on duty shall be deemed the practice of pharmacy and may be grounds for disciplinary action against the pharmacy permit.

C. When the ~~pharmacist-in-charge~~ PIC ceases practice at a pharmacy or no longer wishes to be designated as ~~pharmacist-in-charge~~ PIC, he shall take a complete and accurate inventory of all Schedule II through V controlled substances on hand and shall immediately return the pharmacy permit to the board. *A PIC who is absent from practice for more than 30 consecutive days shall be deemed to no longer be the PIC. Pharmacists-in-charge having knowledge of upcoming absences for longer than 30 days shall be responsible for notifying the board, returning the permit, and taking the required inventory. For unanticipated absences by the PIC, which exceed 15 days with no known return date within the next 15 days, the owner shall immediately notify the board and shall obtain a new PIC.*

D. An application for a permit designating the new ~~pharmacist-in-charge~~ PIC shall be filed with the required fee within 14 days of the original date of resignation or termination of the PIC on a form provided by the board. It shall be unlawful for a pharmacy to operate without a new permit past the 14-day deadline *unless the board receives a request for an extension prior to the deadline. The executor director for the board may grant an extension for up to an additional 14 days for good cause shown.*

18 VAC 110-20-120. Special or limited-use pharmacy permits.

For good cause shown, the board may issue a special or limited-use pharmacy permit, when the scope, degree or type of pharmacy practice or service to be provided is of a special, limited or unusual nature as compared to a regular pharmacy service. The permit to be issued shall be based on special conditions of use requested by the applicant and imposed by the board in cases where certain requirements of regulations may be waived. The following conditions shall apply:

1. The application shall list the regulatory requirements for which a waiver is requested and a brief explanation as to why each requirement should not apply to that practice.

2. A policy and procedure manual detailing the type and method of operation, hours of operation, *schedules of drugs to be maintained by the pharmacy*, and method of documentation of continuing pharmacist control must accompany the application.

3. The issuance and continuation of such permits shall be subject to continuing compliance with the conditions set forth by the board.

18 VAC 110-20-121. Innovative program approval.

A. *An informal conference committee of the board may approve an innovative or pilot program in accordance with § 54.1-3307.2 of the Code of Virginia upon receipt of an application and fee specified in 18 VAC 110-20-20.*

B. *If the informal conference committee determines that an inspection is necessary to adequately consider an application, it may require that the applicant pay a fee specified in 18 VAC 110-20-20 to cover the cost of the inspection.*

C. *If the informal conference committee determines that a technical consultant is necessary in order for the board to make an informed decision on approval of a program, the applicant shall pay a consultant fee, not to exceed the actual cost of the consultation.*

D. *In the initial order granting approval of a program, the informal conference committee shall set the approval period with a schedule for submission of required reports and outcome data. The frequency of required reports shall not exceed four times a year.*

E. *The informal conference committee shall determine the appropriate fee for continued approval of the program based on the requirements for review and monitoring. Such renewal fee shall not exceed \$200 per approval period.*

18 VAC 110-20-130. Pharmacy closings; going out of business; change of ownership.

A. At least 14 days prior to the date a pharmacy closes in accordance with § 54.1-3434.01 of the Code of Virginia or goes out of business, the owner shall notify the board. The proposed disposition of all Schedule II through VI drugs, prescription dispensing records, patient information records, and other required records shall be reported to the board. If the pharmacy drug stock and records are to be transferred to another licensee, the owner shall inform the board of the name and address of the licensee to whom the drugs and records are being transferred and the date of transfer.

B. Exceptions to the public notice as required in § 54.1-3434.01 of the Code of Virginia and the notice required in subsection A of this section shall be approved by the board and may include sudden closing due to fire, destruction, natural disaster, death, property seizure, eviction, bankruptcy, or other emergency circumstances. *If the pharmacy is not able to meet the notification requirements of § 54.1-3434.01, the owner shall ensure that the board and public are properly notified as soon as he knows of the closure and shall disclose*

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the emergency circumstances preventing the notification within the required deadlines.

C. In the event of an exception to the notice as required in § 54.1-3434.01 of the Code of Virginia and in subsection A of this section, the ~~pharmacist in charge~~ PIC or owner shall provide notice as far in advance of closing as allowed by the circumstances.

D. At least 14 days prior to any change in ownership of an existing pharmacy, the owner shall notify the board of the pending change.

1. Upon any change in ownership of an existing pharmacy, the prescription dispensing records for the two years immediately preceding the date of change of ownership and other required patient information shall be provided to the new owners on the date of change of ownership in substantially the same format as previously used immediately prior to the transfer to provide continuity of pharmacy services.

2. The previous owner shall be held responsible for assuring the proper and lawful transfer of records on the date of the transfer.

3. The format of the prescription dispensing records which are transferred to a new owner shall comply with the requirements of Chapter 34 (§ 54.1-3400 et seq.) of Title 54.1 of the Code of Virginia, and this chapter. Failure to comply with this chapter during a change in ownership shall be deemed to be a closing of the existing pharmacy for which the existing pharmacy owner shall be required to provide notice to the board and public in accordance with § 54.1-3434.01 of the Code of Virginia and subsection A of this section.

18 VAC 110-20-135. Change of hours in an existing pharmacy.

~~A~~ *The owner of the pharmacy shall be responsible for providing notice for a change in the hours of operation shall be given to the public and to the board in accordance with § 54.1-3434 of the Code of Virginia unless the change is necessitated by emergency circumstances beyond the control of the pharmacist in charge or owner, or unless the change will result in an expansion of the current hours of operation. If the pharmacy is not able to post the changes 14 days in advance, as required by § 54.1-3434, the owner shall notifiy ensure that the board is notified as soon as he knows of the change and disclose the emergency circumstances preventing the required notification.*

18 VAC 110-20-140. New pharmacies, acquisitions and changes to existing pharmacies.

A. Any person wishing to open a new pharmacy, engage in the acquisition of an existing pharmacy, change the location of an existing pharmacy, or move the location or make structural changes to an existing prescription department, ~~or make changes to a previously approved security system~~ shall file an application with the board.

B. In the acquisition of an existing pharmacy, if prescription records are to be accessible to anyone for purposes other than for continuity of pharmacy services at substantially the

same level offered by the previous owner or for the necessary transfer of prescription records, the owner of the pharmacy acquiring the records shall disclose such information in writing to each patient 14 days prior to the acquisition. Such release of prescription records shall be allowed only to the extent authorized by § 32.1-127.1:03 of the Code of Virginia.

C. The proposed location or structural changes shall be inspected by an authorized agent of the board prior to issuance of a permit.

1. Pharmacy permit applications which indicate a requested inspection date, or requests which are received after the application is filed, shall be honored provided a 14-day notice is allowed prior to the requested inspection date.

2. Requested inspection dates which do not allow a 14-day notice to the board may be adjusted by the board to provide 14 days for the scheduling of the inspection.

3. At the time of the inspection, the dispensing area shall comply with 18 VAC 110-20-150, 18 VAC 110-20-160, 18 VAC 110-20-170, 18 VAC 110-20-180, and 18 VAC 110-20-190.

4. *If an applicant substantially fails to meet the requirements for issuance of a permit and a reinspection is required, or if the applicant is not ready for the inspection on the established date and fails to notify the inspector or the board at least 24 hours prior to the inspection, the applicant shall pay a reinspection fee as specified in 18 VAC 110-20-20 prior to a reinspection being conducted.*

~~D. Upon completion of the inspection, the executive director of the board shall review the findings of the inspection. Drugs shall not be stocked within the proposed pharmacy or moved to a new location until approval is granted or the permit is issued by the executive director of the board or his designee by the inspector or board staff.~~

18 VAC 110-20-150. Physical standards for all pharmacies.

A. The prescription department shall not be less than 240 square feet. The patient waiting area or the area used for *counseling*, devices, cosmetics, and proprietary medicines shall not be considered a part of the minimum 240 square feet. The total area shall be consistent with the size and scope of the services provided.

B. Access to stock rooms, rest rooms, and other areas other than an office that is exclusively used by the pharmacist shall not be through the prescription department. A rest room in the prescription department, used exclusively by pharmacists and personnel assisting with dispensing functions, may be allowed provided there is another rest room outside the prescription department available to other employees and the public. This subsection shall not apply to prescription departments in existence prior to the effective date of this chapter.

C. The pharmacy shall be constructed of permanent and secure materials. Trailers or other moveable facilities or temporary construction shall not be permitted.

D. The entire area of the location of the pharmacy practice, including all areas where drugs are stored shall be well lighted

and well ventilated; the proper storage temperature shall be maintained to meet USP-NF specifications for drug storage.

E. The prescription department counter work space shall be used only for the compounding and dispensing of drugs and necessary record keeping.

F. A sink with hot and cold running water shall be within the prescription department.

G. Adequate refrigeration facilities equipped with a monitoring thermometer for the storage of drugs requiring cold storage temperature shall be maintained within the prescription department, if the pharmacy stocks such drugs.

18 VAC 110-20-160. Sanitary conditions.

A. The entire area of any place bearing the name of a pharmacy shall be maintained in a clean and sanitary manner and in good repair and order.

~~B. The prescription department and work counter space and equipment in the dispensing area shall be maintained in a clean and orderly manner.~~

~~C. B.~~ Adequate trash disposal facilities and receptacles shall be available.

18 VAC 110-20-170. Required minimum equipment or resources.

The ~~pharmacist in charge~~ PIC shall be responsible for maintaining the following ~~equipment~~:

1. A current dispensing information reference source *consistent with the scope of pharmacy practice at the location of the permitted pharmacy.*
2. A set of Prescription Balances, sensitive to 15 milligrams, and weights or an electronic scale *if the pharmacy engages in dispensing activities that require the weighing of components.*
- ~~3. A copy of the current Virginia Drug Control Act and board regulations.~~
4. 3. Other equipment, supplies, and references consistent with the pharmacy's scope of practice and with the public safety.

18 VAC 110-20-180. Security system.

A device for the detection of breaking shall be installed in each prescription department of each pharmacy. The installation and the device shall be based on accepted burglar alarm industry standards, and shall be subject to the following conditions:

1. The device shall be a sound, microwave, photoelectric, ultrasonic, or any other generally accepted and suitable device.
2. The device shall be maintained in operating order and shall have an auxiliary source of power.
3. The device shall fully protect the prescription department and shall be capable of detecting breaking by any means when activated.

4. Access to the alarm system for the prescription department area of the pharmacy shall be restricted to the pharmacists working at the pharmacy, *except for access by other persons in accordance with 18 VAC 110-20-190 B 2*, and the system shall be activated whenever ~~these areas are~~ *the prescription department is* closed for business.

5. This chapter shall not apply to pharmacies which have been granted a permit prior to the effective date of this chapter provided that a previously approved security alarm system is in place, that no structural changes are made in the prescription department, that no changes are made in the security system, that the prescription department is not closed while the rest of the business remains open, and provided further that a breaking and loss of drugs does not occur.

6. If the prescription department was located in a business with extended hours prior to the effective date of this chapter and had met the special security requirements by having a floor to ceiling enclosure, a separately activated alarm system shall not be required.

7. This section shall not apply to pharmacies which are open and staffed by pharmacists 24 hours a day. If the pharmacy changes its hours or if it must be closed for any reason, the ~~pharmacist in charge~~ PIC or owner must immediately notify the board and have installed within 72 hours a security system which meets the requirements of subdivisions 1 through 4 of this section.

18 VAC 110-20-190. Prescription department enclosures; access to prescription department.

A. The prescription departments of each pharmacy shall be provided with enclosures subject to the following conditions:

1. The enclosure shall be constructed in such a manner that it protects the controlled drug stock from unauthorized entry and from pilferage at all times whether or not a pharmacist is on duty.
2. The enclosure shall be of sufficient height as to prevent ~~anyone~~ *a person* from reaching over to gain access to the drugs.
3. Entrances to the enclosed area must have a door with no more than a six-inch gap from the floor and which is at least as high as the adjacent structure. The requirement for a maximum six-inch gap shall not apply to those pharmacies in existence prior to February 3, 1999, with the exception of any pharmacy which experiences a related diversion or theft.
4. Doors to the area must have locking devices which will prevent unauthorized entry in the absence of the pharmacist.

B. The door keys *or other means of entry* and alarm access code to the dispensing areas shall be subject to the following requirements:

1. Only pharmacists practicing at the pharmacy and authorized by the ~~pharmacist in charge~~ PIC shall be in possession of any keys to *or other means of opening* the

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locking device on the door to such enclosure, or to the alarm access code.

2. The pharmacist may place a key or other means of opening the locking device and the alarm access code in a sealed envelope or other container with the pharmacist's signature across the seal in a safe or vault within the pharmacy or other secured place. This key or code shall only be used to allow entrance to the prescription department by other pharmacists, or by a pharmacy technician in accordance with subsection D of this section. In lieu of the pharmacist's signature across a seal, the executive director for the board may approve other methods of securing the emergency keys or access codes to the prescription department.

C. The prescription department is restricted to pharmacists and ~~interns~~ who are practicing at the pharmacy. ~~Clerical assistants~~ Interns, pharmacy technicians, and other persons designated by the pharmacist may be allowed access by the pharmacist but only during the hours the pharmacist is on duty.

D. Upon a request by a patient to obtain an already-dispensed prescription, a pharmacy technician may enter the pharmacy for the sole purpose of retrieving filled prescriptions that have already been reviewed and certified for accuracy by a pharmacist and deemed ready for delivery to the patient if:

1. There is an unforeseen, unplanned absence of a pharmacist scheduled to work during regular prescription department hours;
2. Alternate pharmacist coverage cannot immediately be obtained;
3. The technician is accompanied by a member of the pharmacy's management or administration; and
4. All requirements of subsection E of this section are met.

E. Requirements for entry into the prescription department in the absence of a pharmacist.

1. The requirements for prescriptions awaiting delivery in subsection A of 18 VAC 110-20-200 are followed.
2. Prior to entry into the prescription department, the pharmacy technician shall obtain verbal permission from the PIC or another pharmacist regularly employed by that pharmacy to obtain and use the emergency key or other access and alarm access code and enter the pharmacy.
3. A record shall be made by the pharmacy technician of the entry to include the date and time of entry; the name and signature of the pharmacy technician; the name, title, and signature of the person accompanying the pharmacy technician; the pharmacist's name granting permission to enter and telephone number where the pharmacist was reached; the name of the patient initially requesting needed medication and the nature of the emergency; a listing of all prescriptions retrieved during that entry; and the time of exit and re-securing of the prescription department.
4. The pharmacy technician shall reseal the key and alarm access code after the pharmacy is re-secured, and the PIC shall have the alarm access code changed within 48 hours

of such an entry and shall document that this has been accomplished on the record of entry.

5. All records related to entry by a pharmacy technician shall be maintained for a period of one year on premises.

18 VAC 110-20-200. Storage of drugs, devices, and controlled paraphernalia; expired drugs.

A. Prescriptions awaiting delivery. Prescriptions prepared for delivery to the patient may be placed in a secure place outside of the prescription department and access to the prescriptions restricted by the pharmacist to designated clerical assistants. With the permission of the pharmacist, the prepared prescriptions may be transferred to the patient at a time when the pharmacist is not on duty. If a prescription is delivered at a time when the pharmacist is not on duty, written procedures shall be established and followed by the pharmacy which detail security of the dispensed prescriptions and a method of compliance with counseling requirements of § 54.1-3319 of the Code of Virginia. Additionally, a log shall be made and maintained of all prescriptions delivered to a patient when a pharmacist is not present to include the patient's name, prescription number(s), date of delivery, and the signature of the person receiving the prescription. Such log shall be maintained for a period of one year.

B. Dispersion of Schedule II drugs. Schedule II drugs shall either be dispersed with other schedules of drugs or shall be maintained within a securely locked cabinet, drawer, or safe. The cabinet, drawer, or safe may remain unlocked during hours that the prescription department is open and a pharmacist is on duty.

C. Safeguards for controlled paraphernalia. Controlled paraphernalia shall not be placed on open display or in an area completely removed from the prescription department whereby patrons will have free access to such items or where the pharmacist cannot exercise reasonable supervision and control.

D. Expired drugs; security. Any drug which has exceeded the expiration date shall not be dispensed or sold; it shall be separated from the stock used for dispensing. Expired prescription drugs shall be maintained in a designated area within the prescription department until proper disposal.

18 VAC 110-20-210. Disposal of drugs by pharmacies.

If a ~~pharmacist in charge~~ PIC wishes to dispose of unwanted drugs, he shall use one of the following procedures:

1. Transfer the drugs to another person or entity authorized to possess or provide for proper disposal of such drugs; or
2. Destroy the drugs by burning in an incinerator in compliance with all applicable local, state, and federal laws and regulations. If Schedule II through V drugs are to be destroyed, the following procedures shall apply:
 - a. At least 14 days prior to the destruction date, the ~~pharmacist in charge~~ PIC shall provide a written notice to the board office; the notice shall state the following:

- (1) Date, time, manner, and place of destruction.

(2) The names of the pharmacists who will witness the destruction process.

b. If the destruction date is to be changed or the destruction does not occur, a new notice shall be provided to the board office as set forth above in subdivision 2 of this section.

c. The actual destruction shall be witnessed by the ~~pharmacist in charge PIC~~ and another pharmacist not employed by the pharmacy.

d. The DEA drug destruction form shall be fully completed and used as the record of all drugs to be destroyed. A copy of the destruction form shall be retained at the pharmacy with other inventory records.

18 VAC 110-20-220. General requirements for pharmacies providing radiopharmaceutical services.

A. A permit to operate a pharmacy providing radiopharmaceutical services shall be issued only to a qualified nuclear pharmacist as defined in 18 VAC 110-20-230. In emergency situations, in the absence of the nuclear pharmacist, he may designate one or more other qualified pharmacists to have access to the licensed area. These individuals may obtain single doses of radiopharmaceuticals for the immediate emergency and shall document such withdrawals in the control system.

B. Pharmacies providing ordinary pharmacy services in addition to radiopharmaceutical services shall comply with all regulations applicable to pharmacies in general. Pharmacies providing only radiopharmaceutical services shall comply with all regulations related to physical standards, sanitary conditions and security.

~~C. The nuclear pharmacy area shall be separate from the pharmacy areas for nonradioactive drugs and shall be secured from unauthorized personnel. All pharmacies handling radiopharmaceuticals shall provide a radioactive storage and product decay area, occupying at least 25 square feet of space, separate from and exclusive of the hot laboratory, compounding, dispensing, quality assurance and office areas. Nuclear pharmacies shall have adequate space and equipment, commensurate with the scope of services required and provided and in compliance with standards and requirements of the Nuclear Regulatory Commission (NRC) and the Virginia Department of Health.~~

D. Radiopharmaceuticals are to be dispensed only upon an order from a practitioner authorized to possess, use and administer radiopharmaceuticals.

1. Orders shall originate at an institution or healthcare facility licensed to receive and possess radiopharmaceuticals, and must contain all necessary information relative to the radiopharmaceutical, activity, time of calibration, and any special preparation or delivery instructions.

2. Orders for radiopharmaceuticals may be transmitted orally, by fax, or by electronic transmission by an authorized agent of the prescriber. If the fax or electronic transmission of the authorized agent is pursuant to an oral order from the prescriber, the transmitted document need not include the

prescriber's signature, but must include the name of the agent.

~~E.~~ E. The immediate outside container of a radioactive drug to be dispensed shall also be labeled in accordance with requirements of § 54.1-3410.1 B of the Code of Virginia.

~~F.~~ F. The immediate inner container shall be labeled with: (i) the standard radiation symbol; (ii) the words "Caution--Radioactive Material"; and (iii) the serial number assigned to the order.

~~F.~~ G. The amount of radioactivity shall be determined by radiometric methods for each individual dose immediately prior to dispensing.

~~G.~~ H. Nuclear pharmacies may redistribute approved radioactive drugs if the pharmacy does not process the radioactive drugs in any manner nor violate the product packaging.

18 VAC 110-20-240. Manner of maintaining records, prescriptions, inventory records.

A. Each pharmacy shall maintain the inventories and records of drugs as follows:

1. Inventories and records of all drugs listed in Schedules I and II shall be maintained separately from all other records of the pharmacy.

2. Inventories and records of drugs listed in Schedules III, IV, and V may be maintained separately or with records of Schedule VI drugs but shall not be maintained with other records of the pharmacy.

3. All ~~records~~ *executed order forms, prescriptions, and inventories* of Schedule II through V drugs shall be maintained at the same location as the stock of drugs to which the records pertain ~~except that~~ . *If authorized by DEA, other records pertaining to Schedule II through V drugs, such as invoices, may be maintained in an off-site database or in secured storage. All records in off-site storage shall be retrieved and made available for inspection or audit within 48 hours of a request by the board or an authorized agent.*

4. In the event that an inventory is taken as the result of a theft of drugs pursuant to § 54.1-3404 of the Drug Control Act, the inventory shall be used as the opening inventory within the current biennial period. Such an inventory does not preclude the taking of the required inventory on the required biennial inventory date.

5. All inventories required by § 54.1-3404 of the Code of Virginia shall be signed and dated by the person taking the inventory and shall indicate whether the inventory was taken prior to the opening of business or after close of business. A 24-hour pharmacy with no opening or closing of business shall clearly document whether the receipt or distribution of drugs on the inventory date occurred before or after the inventory was taken.

6. All records required by this section shall be filed chronologically.

B. Prescriptions.

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1. A hard copy prescription shall be placed on file for every initial prescription dispensed and be maintained for two years from the date of last refill. All prescriptions shall be filed chronologically by date of initial dispensing.

2. Schedule II drugs. Prescriptions for Schedule II drugs shall be maintained in a separate prescription file.

3. Schedule III through V drugs. Prescriptions for Schedule III through V drugs shall be maintained either in a separate prescription file for drugs listed in Schedules III, IV, and V only or in such form that they are readily retrievable from the other prescriptions of the pharmacy. Prescriptions will be deemed readily retrievable if, at the time they are initially filed, the face of the prescription is stamped in red ink in the lower right corner with the letter "C" no less than one inch high and filed in the prescription file for drugs listed in the usual consecutively numbered prescription file for Schedule VI drugs. However, if a pharmacy employs an automated data processing system or other electronic recordkeeping system for prescriptions which permits identification by prescription number and retrieval of original documents by prescriber's name, patient's name, drug dispensed, and date filled, then the requirement to mark the hard copy prescription with a red "C" is waived.

C. Chart orders.

1. A chart order written for a patient in a hospital or long-term care facility, a patient receiving home infusion services, or a hospice patient pursuant to § 54.1-3408.01 A of the Code of Virginia shall be exempt from having to contain all required information of a written prescription provided:

a. This information is contained in other readily retrievable records of the pharmacy; and

b. The pharmacy maintains a current policy and procedure manual that sets out where this information is maintained and how to retrieve it and the minimum requirements for chart orders consistent with state and federal law and accepted standard of care.

2. A chart order may serve as the hard copy prescription for those patients listed in subdivision 1 of this subsection.

3. Requirements for filing of chart orders.

a. Chart orders shall be filed chronologically by date of initial dispensing with the following exception: If dispensing data can be produced showing a complete audit trail for any requested drug for a specified time period and each chart order is readily retrievable upon request, chart orders may be filed using another method. Such alternate method shall be clearly documented in a current policy and procedure manual.

b. If a single chart order contains both an order for a Schedule II drug and one or more orders for a drug in another schedule, where the Schedule II drug is not floor stocked, but is dispensed from the pharmacy pursuant to this order for the specific patient, the original order must be filed with records of dispensing of Schedule II drugs and a copy of the order placed in the file for other schedules.

18 VAC 110-20-250. Automated data processing records of prescriptions.

A. An automated data processing system may be used for the storage and retrieval of original and refill dispensing information for prescriptions instead of manual record keeping requirements, subject to the following conditions:

1. A hard copy prescription shall be placed on file as set forth in 18 VAC 110-20-240 B- with the following provisions:

a. *In lieu of a hard copy file for Schedule VI prescriptions, an electronic image of a prescription may be maintained in an electronic database provided it preserves and provides an exact image of the prescription that is clearly legible and made available within 48 hours of a request by a person authorized by law to have access to prescription information.*

b. *If the pharmacy system's automated data processing system fields are automatically populated by an electronic transmission, the automated record shall constitute the prescription and a hard copy or electronic image is not required.*

c. *Storing electronic images of prescriptions for Schedule II-V controlled substances instead of the hard copy shall only be authorized if such storage is allowed by federal law.*

2. Any computerized system shall provide retrieval (via computer monitor display or printout) of original prescription information for those prescriptions which are currently authorized for dispensing.

3. Any computerized system shall also provide retrieval via computer monitor display or printout of the dispensing history for prescriptions dispensed during the past two years.

4. Documentation of the fact that the information entered into the computer each time a pharmacist fills a prescription for a drug is correct shall be provided by the individual pharmacist who makes use of such system. ~~If the system provides a printout is maintained~~ of each day's prescription dispensing data, the printout shall be verified, dated and signed by the individual pharmacist who dispensed the prescription. The individual pharmacist shall verify that the data indicated is correct and then sign the document in the same manner as his name appears on his pharmacist license (e.g., J. H. Smith or John H. Smith).

~~In place of such printout, the pharmacy shall maintain~~ *If a bound log book, or separate file, in which is maintained rather than a printout, each individual pharmacist involved in dispensing shall sign a statement each day in the log, in the manner previously described, attesting to the fact that the dispensing information entered into the computer that day has been reviewed by him and is correct as shown.*

B. Printout of dispensing data requirements. Any computerized system shall have the capability of producing a printout of any dispensing data which the user pharmacy is responsible for maintaining under the Drug Control Act (§ 54.1-3400 et seq. of the Code of Virginia) and such printout

shall be provided within 48 hours of a request of an authorized agent.

18 VAC 110-20-280. Transmission of a prescription order by facsimile machine.

A. Prescription orders for Schedule III through VI drugs may be transmitted to pharmacies by facsimile device (FAX) upon the following conditions:

1. ~~The transmission shall occur~~ *prescription shall be faxed only with permission of the patient to the pharmacy of the patient's choice.*
2. A valid faxed prescription shall contain all required information for a prescription, ~~including~~. *A written prescription shall include the prescriber's signature.*
3. An authorized agent, as defined in § 54.1-3408.01 D of the Code of Virginia, may transmit an oral prescription by facsimile and ~~may sign the prescription in lieu of the prescriber~~ *shall record on the faxed prescription the agent's full name and wording that clearly indicates that the prescription being transmitted is an oral prescription.*
- ~~3.~~ 4. A faxed prescription shall be valid only if faxed from the prescriber's practice location ~~and only if~~, *except for forwarding a faxed chart order from a long-term care facility or from a hospice.*
5. The following additional information ~~is~~ *shall be* recorded on the ~~faxed~~ prescription ~~prior to faxing~~:
 - ~~a.~~ *Documentation that the prescription has been faxed;*
 - ~~b.~~ *a. The date that the prescription was faxed;*
 - ~~c.~~ *b. The printed name, address, phone number, and fax number of the authorized prescriber and the pharmacy to which the prescription was faxed; and*
 - ~~d.~~ *c. The institution, if applicable, from which the prescription was faxed, including address, phone number and fax number.*

B. Prescription orders for Schedule II drugs may only be faxed for information purposes and may not serve as the original written prescription authorizing dispensing, except for orders to be administered to nursing home and home infusion patients in accordance with § 54.1-3408.01 C of the Code of Virginia and except for prescriptions written for a Schedule II narcotic substance for patients residing in a hospice certified by Medicare under Title XVIII or licensed by the state. The prescriber shall note on the prescription if the patient is a hospice patient, and the prescription shall meet all requirements for a written prescription, including the prescriber's signature.

C. If the faxed prescription is of such quality that the print will fade and not remain legible for the required retention period, the receiving pharmacist shall copy or transcribe the faxed prescription on paper of permanent quality.

D. Authorizations for refills may be faxed by the prescriber to the pharmacy provided the authorization includes patient name, address, drug name and strength, quantity, directions for use, prescriber's name, prescriber's signature or agent's name, and date of authorization.

18 VAC 110-20-285. Electronic transmission of prescriptions from prescriber to pharmacy.

A. Unless otherwise prohibited by law, prescriptions may be transmitted by electronic means from the prescriber or an authorized agent as defined in § 54.1-3408.01 D of the Code of Virginia for transmission of oral prescriptions directly to the dispensing pharmacy. *For electronic transmission of Schedule II-V prescriptions, transmissions shall comply with any security or other requirements of federal law. All electronic transmissions shall also comply with all security requirements of state law related to privacy of protected health information.*

B. In addition to all other information required to be included on a prescription, an electronically transmitted prescription shall include the telephone number of the prescriber, the full name of the prescriber's agent if other than the prescriber transmitting, *and* date of transmission, ~~and the identity of the receiving pharmacy.~~

C. A pharmacy receiving an electronic transmission prescription shall ~~either receive the prescription in hard copy form or shall print out a hard copy of the prescription from the pharmacy's computer memory. Any hard copy of a prescription shall be maintained on paper of permanent quality and shall be placed on file in accordance with 18 VAC 110-20-240-B~~ *maintain such prescription record in accordance with 18 VAC 110-20-250 A.*

D. An electronically transmitted prescription shall be transmitted only to the pharmacy of the patient's choice.

18 VAC 110-20-330. Labeling of prescription as to content and quantity.

Unless otherwise directed by the prescribing practitioner, any drug dispensed pursuant to a prescription shall bear on the label of the container, in addition to other requirements of §§ 54.1-3410 and 54.1-3463 of the Code of Virginia, the following information:

1. The drug name and strength, when strength is applicable:
 - a. For any drug product possessing a single active ingredient, the generic name of the drug shall be included on the label.
 - b. If a generic drug is dispensed when a prescription is written for a brand name drug, the label shall contain the generic name followed by the words "generic for" followed by the brand name of the drug prescribed, and the label shall also contain the generic's brand name or the manufacturer or distributor of the drug dispensed.
 - c. The requirements of subdivisions 1 a and b of this section shall not apply to drugs dispensed to patients of a hospital or long-term care facility where all drugs are administered by persons licensed to administer.*

2. The number of dosage units or, if liquid, the number of milliliters dispensed.

18 VAC 110-20-350. Special packaging.

A. Each drug dispensed to a person in a household shall be dispensed in special packaging except when otherwise directed in a prescription by a practitioner, when otherwise

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requested by the purchaser, or when such drug is exempted from 16 CFR §1702.1 et seq. promulgated pursuant to the Poison Prevention Packaging Act of 1970 (15 USC §§1471-1476).

B. Each pharmacy may have a sign posted near the prescription department advising the patients that nonspecial packaging may be requested.

C. If nonspecial packaging is requested, a signed release of such request shall be obtained pursuant to § 54.1-3427 of the Code of Virginia from the patient or the patient's authorized agent and maintained for two years from the date of dispensing.

18 VAC 110-20-355. Pharmacy repackaging of drug; records required; labeling requirements.

A. Pharmacies in which bulk reconstitution of injectable, bulk compounding or the prepackaging of drugs is performed shall maintain adequate control records for a period of one year or until the expiration, whichever is greater. The records shall show the name of the drug(s) used; strength, if any; date repackaged; quantity prepared; initials of the pharmacist supervising verifying the process; the assigned lot or control number; the manufacturer's or distributor's name and lot or control number; and an expiration date.

B. The drug name; strength, if any; the assigned lot or control number or the manufacturer's or distributor's name and lot or control number; and an appropriate expiration date determined by the pharmacist in accordance with USP guidelines shall appear on any subsequently repackaged or reconstituted units as follows:

~~1. If U.S.P. N.F. Class B or better packaging material is used for oral unit dose packages, an expiration date not to exceed six months or the expiration date shown on the original manufacturing bulk container, whichever is less, shall appear on the repackaged or reconstituted units.~~

~~2. If it can be documented that the repackaged unit has a stability greater than six months, an appropriate expiration date may be assigned.~~

~~3. If U.S.P. N.F. Class C or less packaging material is used for oral, solid medication, an expiration date not to exceed 30 days shall appear on the repackaged or reconstituted units.~~

C. Pharmacies using automated counting devices or dispensers in which drugs are removed from manufacturer's original packaging and placed in bulk bins shall record for each bin the drug name; strength, if any; the name of the manufacturer or distributor; the manufacturer's control or lot number; any assigned lot or control number; and an expiration date which does not exceed six months from the date of repackaging and which also does not exceed the manufacturer's expiration date. A drug with two separate manufacturers' or assigned lot or control numbers may be mixed in the same bin provided the expiration date of the older lot is used for the record and provided that the device clears all of the older lot before a third lot is added. comply with the following requirements:

1. A filling record shall be maintained, manually or in a computerized record from which information can be readily retrieved, for each bin including:

a. The drug name and strength, if any;

b. The name of the manufacturer or distributor;

c. Manufacturer's control or lot number(s) for all lots placed into the bin at the time of filling;

d. Any assigned lot number; and

e. An expiration date determined according to USP guidelines for repackaging.

2. If more than one lot is added to a bin at the same time, the lot which expires first shall be used to determine the expiration date if shorter than a calculated date based on USP guidelines.

3. Each bin shall be labeled in such a manner as to cross-reference the information on the filling record with the correct expiration date.

4. If only one lot is added to a bin at one time, but a second lot may be added before the first has cleared, the automated device shall be constructed to reasonably dispense the first lot before the second lot is dispensed, the expiration date on the bin's label shall reflect the expiration date assigned to the earlier lot, and the bin shall be allowed to "run dry" where all product is completely removed prior to filling at least once every 60 days with a record made of the run dry dates.

18 VAC 110-20-360. Issuing a copy of a prescription that can be filed or refilled.

A. Consistent with federal laws and regulations, a copy of a prescription shall be given upon request by one pharmacy to another pharmacist pharmacy provided the drug can be filled or refilled pursuant to §§ 54.1-3410 and 54.1-3411 of the Code of Virginia and provided the patient has given permission for the transfer.

B. The transfer of original prescription information for a drug listed in Schedules III through VI for the purpose of refill dispensing is permissible between pharmacies if the transfer is communicated directly between the two pharmacists pharmacies either orally by direct communication between the transferring pharmacist and the receiving pharmacist, or by facsimile machine or by electronic transmission, and provided:

1. The transferring pharmacist records the following information pharmacy:

1. a. Records the word "VOID" on the face of the invalidated prescription;

2. b. Records on the reverse of the invalidated prescription the name, address, and , except for a prescription for a Schedule VI drug, the Drug Enforcement Administration (DEA) registry number of the pharmacy to which it was transferred, except for a prescription for a Schedule VI drug and, for an oral transfer, and the name of the pharmacist receiving the prescription information; and

~~3. c. Records the date of the transfer and, in the case of an oral transfer, the name of the pharmacist transferring the information, or in the case of an electronic transmission, the name of the pharmacist releasing the information; and~~

~~G. 2. The pharmacist receiving the transferred prescription information shall reduce to writing the following pharmacy:~~

~~1. Write a. Writes the word "TRANSFER" on the face of the transferred prescription.~~

~~2. Provide b. Provides all information required to be on a prescription and to include:~~

~~a. (1) Date of issuance of original prescription;~~

~~b. (2) Original number of refills authorized on the original prescription;~~

~~e. (3) Date of original dispensing, if applicable;~~

~~d. (4) Number of valid refills remaining and date of last refill dispensing;~~

~~e. (5) Pharmacy name, address, DEA registry number, except for Schedule VI prescriptions, and original prescription number from which the prescription information was transferred; and~~

~~f. (6) Name of transferring pharmacist, if transferred orally.~~

~~3. Both the original and transferred prescription shall be maintained for a period of two years from the date of last refill.~~

~~D. C. Nothing in this chapter shall prevent the giving of a prescription marked "For Information Only" to a patient.~~

~~E. Pharmacists may use computer systems in lieu of recording on the hard copy prescription provided that the system used clearly meets all requirements of subsections B and C of this section while retaining all previous dispensing information. D. In lieu of recording the required information in subsection B of this section on a hard copy prescription, a pharmacy may record all required information in an automated data processing system used for storage and retrieval of dispensing information in accordance with 18 VAC 110-20-250.~~

~~F. E. For prescriptions transferred between pharmacies using a common database, the pharmacy receiving the prescription shall not be required to maintain a hard copy pursuant to 18 VAC 110-20-240 B provided that the system used is capable of generating a hard copy of the transferred prescription upon request or except as required by federal law.~~

~~**18 VAC 110-20-370. Issuing a copy of a prescription that cannot be refilled. (Repealed.)**~~

~~A. A copy of a prescription for a drug which, pursuant to § 54.1-3411 of the Drug Control Act, cannot be refilled at the time the copy is requested, shall be given on request of a patient but such copy shall be marked with the statement "FOR INFORMATION ONLY," the patient's name and address, the date of the original prescription, and the date the copy was given.~~

~~B. A copy marked in this manner is not a prescription, as defined in § 54.1-3400 of the Drug Control Act, and shall not be refilled.~~

~~C. The original prescription shall indicate that a copy has been issued, to whom it was issued, and the issuing date.~~

~~D. Copies of prescriptions which cannot be refilled and which are transmitted electronically to another pharmacy shall meet all requirements of this section.~~

~~**18 VAC 110-20-380. Confidentiality of patient information. (Repealed.)**~~

~~A pharmacist shall not exhibit, dispense, or reveal any prescription or discuss the therapeutic effects thereof, or the nature or extent of, or the degree of illness suffered by or treatment rendered to, any patient served by the pharmacist with any person other than the patient or his authorized representative, the prescriber, or other licensed practitioner caring for this patient, or a person duly authorized by law to receive such information.~~

~~**18 VAC 110-20-410. Permitted physician licensed by the board.**~~

~~Permitted A. Pursuant to § 54.1-3304 of the Code of Virginia, physicians licensed by the board to dispense drugs, when pharmacy services are not reasonably available, shall be subject to the following sections of this chapter. For purposes of this section, the terms "pharmacist," "pharmacist-in-charge," and "PIC" in the following shall be deemed to mean the physician permitted by the board:~~

~~1. 18 VAC 110-20-110 C and D;~~

~~2. 18 VAC 110-20-130 A;~~

~~3. 18 VAC 110-20-140 A and C;~~

~~4. 18 VAC 110-20-150 except that these requirements shall not apply to physicians licensed prior to [the effective date of this regulation] unless the dispensing area is relocated or remodeled;~~

~~5. 18 VAC 110-20-160;~~

~~6. 18 VAC 110-20-180;~~

~~7. 18 VAC 110-20-190 A, B and C;~~

~~8. 18 VAC 110-20-200;~~

~~9. 18 VAC 110-20-210; and~~

~~10. 18 VAC 110-20-240 through 18 VAC 110-20-410.~~

~~B. A physician may apply for a special or limited use permit in accordance with 18 VAC 110-20-120.~~

~~**18 VAC 110-20-412. Policy and procedure manual.**~~

~~A policy and procedure manual shall be prepared and maintained for the compounding, dispensing and delivery of sterile products that is consistent with USP-NF standards and guidance and shall include at least the following elements:~~

~~1. Personnel qualifications including initial and follow-up training and method of periodic reevaluation of qualifications and performance;~~

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2. Scope of compounding performed at the pharmacy and proper procedures for compounding to include maintaining suitable environmental conditions in the compounding area, wearing appropriate garb to reduce particulate matter and contamination of work area, performing aseptic procedures.

3. Procedures for maintaining and monitoring proper operating conditions for all equipment used in sterile compounding;

4. Guidelines for patient or caretaker education if products are dispensed for home use to include instructions concerning proper storage, aseptic manipulation of the product, proper administration and use of devices if applicable, recognizing signs of instability or incompatibility, and procedures in case of an emergency with the product;

5. Guidelines for assignment of beyond-use dates for all compounded sterile products and justification for any date chosen which exceeds the standard set forth in this chapter;

6. Separate procedures for handling cytotoxic drugs, if applicable, to include protective apparel; disposal procedures consistent with applicable local, state, and federal requirements; procedures for handling spills; special packaging and labeling requirements, and delivery procedures to minimize risks of accidental spills;

7. If applicable, separate procedures for compounding sterile products using nonsterile components or open system transfer techniques and for end-product sterilization of these products.

18 VAC 110-20-415. Quality assurance.

A. The ~~pharmacist in charge~~ PIC in a pharmacy compounding sterile products shall be responsible for maintaining and updating the policy and procedure manual as set forth in 18 VAC 110-20-411 in accordance with current acceptable standards, and for ensuring compliance with the policy and procedure manual.

B. All laminar flow hoods or other environmental control devices shall be certified according to accepted standards for operational efficiency by a qualified independent contractor *initially*, at least every six months *and after relocation*.

18 VAC 110-20-420. Unit dose dispensing system.

A. A unit dose drug dispensing system may be utilized for the dispensing of drugs to patients in a hospital or long-term care facility. The following requirements shall apply regardless of whether licensed or unlicensed persons administer medications:

1. Any equipment outside the pharmacy used to house drugs to be administered in a unit dose system shall be fitted with a locking mechanism and locked at all times when unattended.

2. A signed order by the prescribing practitioner shall accompany the requests for a Schedule II drug, except that a verbal order for a hospital patient for a Schedule II controlled substance may be transmitted to a licensed nurse or pharmacist ~~employed by~~ *employed by* at the hospital who ~~will~~ *shall* promptly reduce the order to writing in the patient's chart.

Such an order shall be signed by the prescriber within 72 hours.

3. Properly trained personnel may transcribe the prescriber's drug orders to a patient profile card, fill the medication carts, and perform other such duties related to a unit dose distribution system provided these are done under the personal supervision of a pharmacist.

4. All dosages and drugs shall be labeled with the drug name, strength, lot number and expiration date when indicated.

5. The patient's individual drug drawer or tray shall be labeled with the patient's name and location.

6. All unit dose drugs intended for internal use shall be maintained in the patient's individual drawer or tray unless special storage conditions are necessary.

7. A back-up dose of a drug of not more than one dose unit may be maintained in the patient's drawer, tray, or special storage area provided that the dose is maintained in the patient's drawer, tray, or special storage area with the other drugs for that patient.

8. A record shall be made and maintained within the pharmacy for a period of one year showing:

a. The date of filling of the drug cart;

b. The location of the drug cart;

c. The initials of the person who filled the drug cart; and

d. The initials of the pharmacist checking and certifying the contents of the drug cart in accordance with the provisions in 18 VAC 110-20-270 B.

9. A patient profile record or medication card will be accepted as the dispensing record of the pharmacy for unit dose dispensing systems only, subject to the following conditions:

a. The record of dispensing must be entered on the patient profile record or medication card at the time the drug drawer or tray is filled.

b. In the case of Schedule II through V drugs, after the patient profile record or medication card has been completed, the card must be maintained for two years.

c. In the case of the computer-based distribution system, a uniformly maintained "fill list" or other document containing substantially the same information may be accepted as the dispensing record for Schedule II through VI drugs. Records of disposition/administration for floor stock drugs as provided in 18 VAC 110-20-460 B will be accepted for drugs distributed as floor stock.

B. In providing unit dose systems to hospitals or long-term care facilities where only those persons licensed to administer are administering drugs, the pharmacy shall dispense not more than a seven-day supply of a drug in a solid, oral dosage form at any one given time.

C. In addition to the requirements listed in subsection A of this section, the following requirements apply to those long-term care facilities in which unlicensed persons administer drugs:

1. The pharmacy providing medications to such facility shall dispense no more than a 72-hour supply of drugs in a solid, oral dosage form at any one given time.
2. The pharmacy shall provide to persons administering medications training specific to the particular unit dose system being used.
3. The pharmacy shall provide a medication administration record to the facility listing each drug to be administered with full dosage directions to include no abbreviations.
4. The drugs in a unit dose system shall be placed in slots within a drawer labeled or coded to indicate time of administration.

18 VAC 110-20-440. Responsibilities of the pharmacist-in-charge.

A. The ~~pharmacist in charge~~ PIC in a pharmacy located within a hospital or the ~~pharmacist in charge~~ PIC of any outside pharmacy providing pharmacy services to a hospital shall be responsible for establishing procedures for and assuring maintenance of the proper storage, security, and dispensing of all drugs used throughout the hospital.

B. The ~~pharmacist in charge~~ PIC of a pharmacy serving a hospital shall be responsible for ~~a monthly review of drug therapy for each patient within the hospital for a length of stay of one month or greater. A record of such review shall be signed and dated by the pharmacist and shall~~ *maintaining a policy and procedure for providing reviews of drug therapy to include but not limited to at a minimum any irregularities in drug therapy, drug interactions, drug administration, or transcription errors. All significant irregularities shall be brought to the attention of the attending practitioner or other person having authority to correct the potential problem.*

C. Prior to the opening of a satellite pharmacy within the hospital, the ~~pharmacist in charge~~ PIC shall notify the board as required by 18 VAC 110-20-140 and shall ensure compliance with subsections B through G of 18 VAC 110-20-150, 18 VAC 110-20-160, ~~subdivisions 5 and 6 of~~ 18 VAC 110-20-170, 18 VAC 110-20-180 and 18 VAC 110-20-190. No drugs shall be stocked in a satellite pharmacy until an inspection has been completed and approval given for opening.

D. For the following list of Schedule VI controlled substances, the PIC of a pharmacy serving a hospital may authorize the storage in an area of the hospital outside the pharmacy, and may delegate the ordering and distribution within the hospital to nonpharmacy personnel provided the conditions for proper storage and adequate security and the procedures for distribution are set forth in the pharmacy's policy and procedure manual, and provided that the PIC assures that these storage areas are checked monthly for compliance. The storage areas must be locked when authorized staff is not present in the area. Except for nitrous oxide, medical gases may be stored in an unlocked area.

1. *Large volume parenteral solutions that contain no active therapeutic drugs other than electrolytes;*
2. *Irrigation solutions;*
3. *Contrast media;*
4. *Medical gases;*
5. *Sterile sealed surgical trays that may include a Schedule VI drug; and*
6. *Blood, blood components and derivatives, and synthetic blood components and products.*

18 VAC 110-20-450. After-hours access to the pharmacy.

When authorized by the ~~pharmacist in charge~~ PIC, a ~~supervisory~~ *an authorized* nurse may have access to the pharmacy in the absence of the pharmacist in order to obtain emergency medication, provided that such drug is available in the manufacturer's original package or in units which have been prepared and labeled by a pharmacist and provided further that a separate record shall be made and left within the pharmacy on a form prescribed by the ~~pharmacist in charge~~ PIC and such records are maintained within the pharmacy for a period of one year showing:

- 1 The date of withdrawal;
2. The patient's name;
3. The name of the drug, strength, dosage form and dose prescribed;
4. Number of doses removed; and
5. The signature of the authorized nurse.

18 VAC 110-20-460. Floor stock drugs; proof of delivery; distribution records.

A. A delivery receipt shall be obtained for Schedule II through V drugs supplied as floor stock. This record shall include the date, drug name and strength, quantity, hospital unit receiving drug and the signatures of the dispensing pharmacist and the receiving nurse. Receipts shall be maintained in the pharmacy for a period of two years *or in off-site storage, which shall be retrievable and made available for inspection or audit within 48 hours of a request by the board or an authorized agent.*

B. A record of disposition/administration shall be used to document administration of Schedule II through V drugs when a floor stock system is used for such drugs. The record shall be returned to the pharmacy within three months of its issue. The ~~pharmacist in charge~~ PIC or his designee shall:

1. Match returned records with delivery receipts to verify that all records are returned;
2. Periodically audit returned administration records for completeness as to patient's names, dose, date and time of administration, signature or initials of person administering the drug, and date the record is returned;
3. Verify that all additions to inventory are recorded, that all additions to and deductions from inventory are correctly calculated, that sums carried from one record to the next are correctly recorded, and periodically verify that doses

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documented on administration records are reflected in the medical record; and

4. Initial ~~or sign~~ the returned record, file chronologically by date of issue, and retain for two years from the date of return *or in off-site storage, which shall be retrievable and made available for inspection or audit within 48 hours of a request by the board or an authorized agent.*

C. The filing requirements of 18 VAC 110-20-240 A 1 for separation of Schedule II records shall be met for administration records if the Schedule II drugs are listed in a separate section on a page that contains other schedules of drugs.

18 VAC 110-20-470. Emergency room.

All drugs in the emergency department shall be under the control and supervision of the ~~pharmacist in charge PIC~~ and shall be subject to the following additional requirements:

1. All drugs kept in the emergency room shall be in a secure place from which unauthorized personnel and the general public are excluded.
2. Oral orders for medications shall be reduced to writing and shall be signed by the practitioner.
3. A medical practitioner may dispense drugs to his patients if in a bona fide medical emergency or when pharmaceutical services are not readily available and if permitted to do so by the hospital; the drug container and the labeling shall comply with the requirements of this chapter and the Drug Control Act.
4. A record shall be maintained of all drugs administered in the emergency room.
5. A separate record shall be maintained on all drugs, including drug samples, dispensed in the emergency room. The records shall be maintained for a period of two years showing:
 - a. Date and time dispensed;
 - b. Patient's name;
 - c. Prescriber's name;
 - d. Name of drug dispensed, strength, dosage form, quantity dispensed, and dose.

18 VAC 110-20-480. Pharmacy services. (Repealed.)

~~A. In addition to service to inpatients, a hospital pharmacy may dispense drugs to the following:~~

- ~~1. Patients who receive treatments or consultations on the premises;~~
- ~~2. Outpatients or emergency patients upon discharge for their personal use away from the hospital; and~~
- ~~3. The hospital employees, medical staff members, or students for personal use or for the use of their dependents. Nothing in this chapter shall prohibit a hospital pharmacy not operated under a separate outpatient pharmacy permit from providing such services or drugs, or both, as are not~~

~~readily available in the community to patients who may not otherwise be served by the hospital pharmacy.~~

~~B. If a pharmacy located within a hospital dispenses drugs to patients other than those listed in subsection A of this section, the pharmacy shall obtain a separate pharmacy permit and shall operate in a space separated from the hospital pharmacy.~~

18 VAC 110-20-490. Automated devices for dispensing and administration of drugs.

A hospital may use automated devices for the dispensing and administration of drugs pursuant to § 54.1-3301 of the Code of Virginia and §§ 54.3401 and 54.1-3434.02 of the Drug Control Act and in accordance with 18 VAC 110-20-270, 18 VAC 110-20-420 or 18 VAC 110-20-460 as applicable. The following conditions shall apply:

1. Prior to removal of drugs from the pharmacy, a delivery record shall be generated for all drugs to be placed in an automated dispensing device which shall include the date; drug name, dosage form, and strength; quantity; hospital unit and a unique identifier for the specific device receiving the drug; initials of the person loading the automated dispensing device; and initials of the pharmacist reviewing the transaction.
2. At the time of loading, the delivery record for all Schedule II through V drugs shall be signed by a nurse or other person authorized to administer drugs from that specific device, and the record returned to the pharmacy and maintained in chronological order for a period of two years from date of delivery. The delivery record and required signatures may be generated or maintained electronically provided the system being used has the capability of recording an electronic signature which is a unique identifier and restricted to the individual receiving the drugs and provided that this record is maintained in a "read-only" format which cannot be altered after the information is recorded. The electronic record shall be readily retrievable, maintained for a period of two years, and the system used shall be capable of producing a hard-copy printout of the record upon request.
3. At the time of loading any Schedule II through V drug, the person loading will verify that the count of that drug in the automated dispensing device is correct. Any discrepancy noted shall be recorded on the delivery record and immediately reported to the pharmacist in charge, who shall be responsible for reconciliation of the discrepancy or properly reporting of a loss.
4. Automated dispensing devices in hospitals shall be capable of producing a hard-copy record of distribution which shall show patient name, drug name and strength, dose withdrawn, dose to be administered, date and time of withdrawal from the device, and identity of person withdrawing the drug.
5. The ~~pharmacist in charge PIC~~ or his designee shall conduct at least a monthly audit ~~and to review of all~~ distribution and administration of Schedule II through V drugs from each automated dispensing device: *as follows:*

a. The audit shall reconcile ~~the records of all quantities of Schedule II through V drugs dispensed from the pharmacy with records of all quantities loaded into the each device and still on hand with the quantities removed from the device for administration. This audit shall also check for compliance with written procedures for security and use of the automated dispensing devices, accuracy of distribution from the device, and proper recordkeeping to detect whether any drugs recorded as removed from the pharmacy were diverted rather than being placed in the proper device.~~

b. A discrepancy report shall be generated for each discrepancy in the count of a drug on hand in the device. Each such report shall be resolved by the PIC or his designee within 72 hours of the time the discrepancy was discovered or, if determined to be a theft or an unusual loss of drugs, shall be immediately reported to the board in accordance with § 54.1-3404 E of the Drug Control Act.

c. The audit shall include a review of a sample of administration records from each device per month for possible diversion by fraudulent charting. A sample from each device shall not be less than 24 consecutive hours within the month being audited.

~~Random checks shall be made~~ d. The audit shall include a check of medical records to ensure that a valid order exists for each dose a random sample of doses recorded as administered.

e. The audit shall also check for compliance with written procedures for security and use of the automated dispensing devices, accuracy of distribution from the device, and proper recordkeeping.

f. The hard-copy distribution and administration records printed out and reviewed in the audit shall be initialed and dated by the person conducting the audit and maintained in the pharmacy for a period of two years. If nonpharmacist personnel conduct the audit, a pharmacist shall review the record and shall initial and date the record. These distribution records reviewed in conducting the audit may be maintained electronically provided they can be readily retrieved upon request; provided they are maintained in a "read-only" format which does not allow alteration of the records; and provided a log is maintained for a period of two years showing dates of audit and review, the identity of the automated dispensing device being audited, the time period covered by the audit and review, and the initials of all reviewers.

6. If an automated dispensing device is used to obtain drugs for dispensing from an emergency room, a separate dispensing record is not required provided the automated record distinguishes dispensing from administration and records the identity of the physician who is dispensing.

7. Automated dispensing devices shall be inspected monthly by pharmacy personnel to verify proper storage, proper location of drugs within the device, expiration dates, the security of drugs and validity of access codes.

8. Personnel allowed access to an automated dispensing device shall have a specific access code which records the identity of the person accessing the device.

9. Proper use of the automated dispensing devices and means of compliance with requirements shall be set forth in the pharmacy's policy and procedure manual.

18 VAC 110-20-500. Licensed emergency medical services agencies program.

The pharmacy may prepare a drug kit for a licensed emergency medical services agency provided:

1. The ~~pharmacist in charge~~ PIC of the hospital pharmacy shall be responsible for all controlled drugs contained in this drug kit.

2. The drug kit is sealed in such a manner that it will preclude any possibility of loss of drugs.

3. Drugs may be administered by a *an emergency medical technician* upon an oral order or written standing order of an authorized medical practitioner in accordance with § 54.1-3408 of the Code of Virginia. Oral orders shall be reduced to writing by the technician and shall be signed by a medical practitioner. Written standing orders shall be signed by the operational medical director for the emergency medical services agency. The *emergency medical technician* shall make a record of all drugs administered to a patient. This administration record shall be signed by the medical practitioner who assumes responsibility for the patient at the hospital. If the patient is not transported to the hospital or if the attending medical practitioner at the hospital refuses to sign the record, a copy of this record shall be signed and placed in delivery to the hospital pharmacy who was responsible for that kit exchange by the agency's operational medical director within seven days of the administration.

4. When the drug kit has been opened, the kit shall be returned to the pharmacy and exchanged for an unopened kit. The record of the drugs administered shall accompany the opened kit when exchanged. An accurate record shall be maintained by the pharmacy on the exchange of the drug kit for a period of one year.

5. The record of the drugs administered shall be maintained as a part of the pharmacy records pursuant to state and federal regulations for a period of not less than two years.

18 VAC 110-20-510. Identification for medical intern or resident prescription form in hospitals.

The prescription form for the prescribing of drugs for use by *attending physicians*, medical interns or residents who prescribe only in a hospital shall bear the prescriber's signature, the legibly printed name, address, and telephone number of the prescriber and an identification number assigned by the hospital. The identification number shall be the Drug Enforcement Administration number assigned to the hospital pharmacy plus a suffix assigned by the institution. The assigned number shall be valid only within the course of duties ~~within the hospital~~ as part of the residency program.

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18 VAC 110-20-530. Pharmacy's responsibilities to long-term care facilities.

The pharmacy serving a long-term care facility shall:

1. Receive a valid order prior to the dispensing of any drug.
2. Ensure that personnel administering the drugs are trained in using the dispensing system provided by the pharmacy.
3. Ensure that the drugs for each patient are kept and stored in the originally received containers and that the medication of one patient shall not be transferred to another patient.
4. Ensure that each cabinet, cart or other area utilized for the storage of drugs is locked and accessible only to authorized personnel.
5. Ensure that the storage area for patients drugs is well lighted, of sufficient size to permit storage without crowding, and is maintained at appropriate temperature.
6. Ensure that poison and drugs for "external use only" are kept in a cabinet and separate from other medications.
7. Provide for the disposition of discontinued drugs under the following conditions:
 - a. Discontinued drugs may be returned to the pharmacy for resale or transferred to another pharmacy for redispensing to the indigent if authorized by § 54.1-3411.1 and 18 VAC 110-20-400, or destroyed by appropriate means in compliance with any applicable local, state, and federal laws and regulations.
 - b. Drug destruction at the pharmacy shall be witnessed by the ~~pharmacist in charge~~ PIC and by another pharmacy employee. *The pharmacy may transfer the drugs for destruction to an entity appropriately licensed to accept returns for destruction.* Drug destruction at the facility shall be witnessed by the director of nursing or, if there is no director, then by the facility administrator and by a pharmacist providing pharmacy services to the facility or by another employee authorized to administer medication.
 - c. A complete and accurate record of the drugs returned or destroyed or both shall be made. The original of the record of destruction shall be signed and dated by the persons witnessing the destruction and maintained at the long-term care facility for a period of two years. A copy of the destruction record shall be maintained at the provider pharmacy for a period of two years.
 - d. ~~All destruction of the drugs shall be done~~ *Long-term care facilities shall destroy discontinued or unused drugs or return them to the pharmacy* without 30 days of the ~~time~~ *date* the drug was discontinued.
8. Ensure that appropriate drug reference materials are available in the facility units.
9. Ensure that a monthly review of drug therapy by a pharmacist is conducted for each patient in long-term care facilities except those licensed under Title 63.1 of the Code of Virginia. Such review shall be used to determine any irregularities, which may include but not be limited to drug

therapy, drug interactions, drug administration or transcription errors. The pharmacist shall sign and date the notation of the review. All significant irregularities shall be brought to the attention of the attending practitioner or other party having authority to correct the potential problem.

18 VAC 110-20-540. Emergency drug kit.

The pharmacist providing services may prepare an emergency kit for a facility in which only those persons licensed to administer are administering drugs under the following conditions:

1. The contents of the emergency kit shall be of such a nature that the absence of the drugs would threaten the survival of the patients.
2. The contents of the kit shall be determined by the provider pharmacist in consultation with the medical and nursing staff of the institutions and shall be limited to drugs for administration by injection or inhalation only, except that Nitroglycerin SL may be included.
3. The kit is sealed in such a manner that it will preclude any possible loss of the drug.
 - a. *The dispensing pharmacy must have a method of sealing such kits so that once the seal is broken, it cannot be reasonably resealed without the breach being detected.*
 - b. *If a seal is used, it shall have a unique numeric or alphanumeric identifier to preclude replication and/or resealing. The pharmacy shall maintain a record of the seal identifiers when placed on a box or kit and maintain the record until such time as the seal is replaced.*
 - c. *In lieu of seals, a kit with a built-in mechanism preventing resealing or relocking once opened except by the provider pharmacy is also acceptable.*
4. *The kit shall have a form to be filled out upon opening the kit and removing contents to write the name of the person opening the kit, the date, time and name and quantity of item(s) removed.* The opened kit is maintained under secure conditions and returned to the pharmacy within 72 hours for replenishing.
5. Any drug used from the kit shall be covered by a prescription, signed by the prescriber, when legally required, within 72 hours.

18 VAC 110-20-550. Stat-drug box.

An additional drug box called a stat-drug box may be prepared by a pharmacy to provide for initiating therapy prior to the receipt of ordered drugs from the pharmacy. A stat-drug box shall be provided to those facilities in which only those persons licensed to administer are administering drugs and shall be subject to the following conditions:

1. The box is sealed in such a manner that will preclude the loss of drugs.
 - a. *The dispensing pharmacy must have a method of sealing such boxes so that once the seal is broken, it cannot be reasonably resealed without the breach being detected.*

b. If a seal is used, it shall have a unique numeric or alphanumeric identifier to preclude replication or resealing, or both. The pharmacy shall maintain a record of the seal identifiers when placed on a box and maintain the record until such time as the seal is replaced.

c. In lieu of seals, a box with a built-in mechanism preventing resealing or relocking once opened except by the provider pharmacy is also acceptable.

2. The box shall have a form to be filled out upon opening the box and removing contents to write the name of the person opening the box, the date, time and name and quantity of item(s) removed. When the stat-drug box has been opened, it is returned to the pharmacy.

3. Any drug used from the box shall be covered by a drug order signed by the prescriber, when legally required, within 72 hours.

4. There shall be a listing of the contents of the box maintained in the pharmacy and also attached to the box in the facility. This same listing shall become a part of the policy and procedure manual of the facility served by the pharmacy.

5. The drug listing on the box shall bear an expiration date for the box. The expiration date shall be the day on which the first drug in the box will expire.

6. The contents of the box shall be limited to those drugs in which a delay in initiating therapy may result in harm to the patient.

a. The listing of drugs contained in the stat-drug box shall be determined by the provider pharmacist in consultation with the medical and nursing staff of the long-term care facility.

b. The stat-drug box shall contain no Schedule II drugs.

c. The stat-drug box shall contain no more than one Schedule III through V drug in each therapeutic class and no more than five doses of each.

18 VAC 110-20-555. Use of automated dispensing devices.

~~A. An automated dispensing device may be used in place of stat drug boxes or emergency drug kits provided the conditions of subdivisions 1, 2, and 5 of 18 VAC 110-20-540 and subdivisions 3 and 6 of 18 VAC 110-20-550 have been met. In addition to these provisions, the drugs placed in these devices shall be limited to the drugs which would have been stocked in the stat drug boxes and emergency kits, and the quantity of any one drug shall not exceed the total quantity which would have been stored at one facility in all stat drug boxes and emergency kits combined. No more than a 48-hour supply per each 50 residents per drug may be stocked in the device. Nursing homes licensed pursuant to Chapter 5 (§ 32.1-123 et seq.) of Title 32.1 of the Code of Virginia may use automated drug dispensing systems, as defined in § 54.1-3401 of the Code of Virginia, upon meeting the following conditions:~~

~~B. The use of such devices is limited to those long term care facilities where only persons holding a license to administer drugs are actually administering. Use of automated dispensing~~

~~devices in long term care facilities shall be in compliance with the following:~~

~~1. Drugs placed in an automated drug dispensing system in a nursing home shall be under the control of the pharmacy providing services to the nursing home, the pharmacy shall have on-line communication with and control of the automated drug dispensing system, and access to any drug for a patient shall be controlled by the pharmacy.~~

~~2. A nursing home without an in-house pharmacy shall obtain a controlled substances registration prior to using an automated dispensing system.~~

~~3. Removal of drugs from any automated drug dispensing system for administration to patients can only be made pursuant to a valid prescription or lawful order of a prescriber. A drug may not be administered to a patient from an automated dispensing device until a pharmacist has reviewed the prescription order and electronically authorized the access of that drug for that particular patient in accordance with the order. The PIC of the provider pharmacy shall ensure that a pharmacist who has on-line access to the system is available at all times to review a prescription order as needed and authorize administering pursuant to the order reviewed.~~

~~4. 4. Drugs placed in automated dispensing devices shall be in the manufacturer's sealed original packaging or in repackaged containers in compliance with the requirements of 18 VAC 110-20-355 relating to repackaging, labeling, and records.~~

~~2- 5. Prior to the removal of drugs from the pharmacy, a delivery record shall be generated for all drugs to be placed in an automated dispensing device which shall include the date; drug name, dosage form, and strength; quantity; nursing home; a unique identifier for the specific device receiving drugs; and initials of the pharmacist checking the order of drugs to be removed from the pharmacy and the records of distribution.~~

~~3. Drugs may be loaded in the device by a pharmacist or by a person licensed to administer drugs working at the long-term care facility. 6. At the direction of the PIC, drugs may be loaded in the device by a pharmacist or a pharmacy technician adequately trained in the proper loading of the system.~~

~~4- 7. At the time of loading, the delivery record for all Schedule II through V drugs shall be signed by a nurse or other person authorized to administer drugs from that specific device, and the record returned to the pharmacy and maintained in chronological order for a period of two years from date of delivery. The delivery record and required signatures may be generated or maintained electronically provided the system being used has the capability of recording an electronic "signature" which is a unique identifier and restricted to the individual receiving the drugs and provided that this record is maintained in a "read-only" format which cannot be altered after the information is recorded. The electronic record shall be readily retrievable, maintained for a period of two years, and the system used shall be capable of producing a hard copy printout of the record upon request.~~

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~~5- 8. At the time of loading any Schedule II through V drug, the person loading will verify that the count of that drug in the automated dispensing device is correct. Any discrepancy noted shall be recorded on the delivery record and immediately reported to the pharmacist-in-charge PIC, who shall be responsible for reconciliation of the discrepancy or the proper reporting of a loss.~~

~~6- The provider pharmacy shall have the capability of on-line communication with any automated dispensing devices in a long-term care facility. The pharmacy shall be capable of producing a hard-copy record of distribution from the device which shall show patient name, drug name and strength, dose withdrawn, dose to be administered, date and time of withdrawal from the device, and the identity of the person withdrawing the drug. Except for emergency or urgent administration during times when a pharmacist is not available, the pharmacist shall review and approve a new order prior to a dose being removed for administration to a patient.~~

~~7- 9. The pharmacist-in-charge PIC of the provider pharmacy or his designee shall conduct at least a monthly audit and to review of all distribution and administration of Schedule II through V drugs from each automated dispensing device- as follows:~~

~~a. The audit shall reconcile the records of all quantities of Schedule II through V drugs dispensed from the pharmacy with records of all quantities loaded into the each device and still on hand with the quantities removed from the device for administration. This audit shall also check for compliance with written procedures for security and use of the automated dispensing devices, accuracy of distribution from the device, and proper recordkeeping. to detect whether any drugs recorded as removed from the pharmacy were diverted rather than being placed in the proper device.~~

~~b. A discrepancy report shall be generated for each discrepancy in the count of a drug on hand in the device. Each such report shall be resolved by the PIC or his designee within 72 hours of the time the discrepancy was discovered or, if determined to be a theft or an unusual loss of drugs, shall be immediately reported to the board in accordance with § 54.1-3404 E of the Drug Control Act.~~

~~c. The audit shall include a review of a sample of administration records from each device per month for possible diversion by fraudulent charting. A sample from each device shall not be less than 24 consecutive hours within the month being audited.~~

~~d. The audit shall include a check by the pharmacy shall be made of medical records to ensure that a valid order exists for each dose administered from the automated dispensing device a random sample of doses recorded as administered.~~

~~e. The audit shall also check for compliance with written procedures for security and use of the automated dispensing devices, accuracy of distribution from the device, and proper recordkeeping.~~

~~f. The hard copy distribution and administration records printed out and reviewed in the audit shall be initialed and dated by the person conducting the audit and maintained in the pharmacy for a period of two years. If the person designated by the pharmacist-in-charge to nonpharmacist personnel conduct the audit is not a pharmacist, a pharmacist shall review the audit record and shall initial and date the record of the audit. These distribution records reviewed in conducting the audit may be maintained electronically provided they can be readily retrieved upon request; provided they are maintained in a "read-only" format which does not allow alteration of the records; and provided a log is maintained for a period of two years showing the dates of audit and review, the identity of the automated dispensing device being audited, the time period covered by the audit and review, and the initials of all reviewers.~~

~~8- 10. Automated dispensing devices shall be inspected monthly by pharmacy personnel to verify proper storage, proper location of drugs within the device, expiration dates, the security of drugs and validity of access codes.~~

~~9- 11. Personnel allowed access to an automated dispensing device shall have a specific access code which records the identity of the person accessing the device.~~

~~10- Proper use of the automated dispensing devices and means of compliance with requirements shall be set forth in the pharmacy's policy and procedure manual. 12. The PIC of the pharmacy providing services to the nursing home shall establish, maintain, and assure compliance with written policy and procedure for the accurate stocking and proper storage of drugs in the automated drug dispensing system, accountability for and security of all drugs maintained in the automated drug dispensing system, preventing unauthorized access to the system, tracking access to the system, complying with federal and state regulations related to the storage and dispensing of controlled substances, maintaining patient confidentiality, maintaining required records, and assuring compliance with the requirements of this chapter.~~

18 VAC 110-20-590. Drugs in correctional institutions.

A. All prescription drugs at any correctional unit shall be obtained only on an individual prescription basis from a pharmacy and subject to the following conditions:

1. All prepared drugs shall be maintained in a suitable locked storage area with only the person responsible for administering the drugs having access.

2. Complete and accurate records shall be maintained of all drugs received, administered and discontinued. The administration record shall show the:

a. ~~Prescription number~~ Patient name;

b. Drug name and strength;

c. Number of dosage units received;

d. Prescriber's name; and

e. Date, time and signature of the person administering the individual dose of drug.

3. All unused or discontinued drugs shall be sealed and the amount in the container at the time of the sealing shall be recorded on the drug administration record. Such drugs shall be returned to the provider pharmacy or to a secondary pharmacy along with the drug administration record within ~~seven~~ 30 days of discontinuance.

a. The provider or secondary pharmacy shall conduct random audits of returned drug administration records for accountability.

b. The drug administration records shall be filed in chronological order by the provider or secondary pharmacy and maintained for a period of one year or, at the option of the facility, the records may be returned by the ~~provider~~ pharmacy to the facility.

c. Drugs may be returned to the ~~provider~~ pharmacy stock in compliance with the provisions of 18 VAC 110-20-400.

d. Other drugs shall be disposed of or destroyed by the provider pharmacy in accordance with local, state, and federal regulations.

Alternatively, drugs for destruction may be forwarded by a pharmacist directly from the correctional facility to a returns company after performing the audit required by subdivision 3 a of this subsection and ensuring the proper maintenance of the administration records.

4- B. Emergency and stat-drug box. An emergency box and a stat-drug box may be prepared for the facility served by the pharmacy pursuant to 18 VAC 110-20-540 and 18 VAC110-20-550 provided that the facility employs one or more full-time physicians, registered nurses, licensed practical nurses, physician assistants or correctional health assistants.

C. Prescription drugs may be stocked at a medical clinic or surgery center that is part of a correctional facility and that is staffed by one or more physicians during the hours of operation provided the clinic first obtains a controlled substances registration and complies with the requirements of 18 VAC 110-20-690, 18 VAC 110-20-700, 18 VAC 110-20-710 and 18 VAC 110-20-720.

18 VAC 110-20-680. Medical equipment suppliers.

A. A medical equipment supplier's location shall be inspected by the board prior to engaging in business. The location shall be clean and sanitary and shall have a system of temperature control to provide for specified storage conditions for any Schedule VI drug or device.

B. Hypodermic needles and syringes and Schedule VI drugs shall not be placed on open display or in an open area where patrons will have access to such items. No Schedule VI devices shall be placed in an area where responsible parties cannot exercise reasonable supervision and control.

C. A medical equipment supplier shall receive a valid order from a practitioner prior to dispensing and shall maintain this order on file on the premises for a period of two years from date of last dispensing. *The original order may be kept at a centralized office as long as it is readily retrievable within 48 hours and a copy of the order is kept on the premises of the dispensing supplier.*

D. Medical equipment suppliers shall make a record at the time of dispensing. This record shall be maintained on the premises for two years from date of dispensing and shall include:

1. Name and address of patient;
2. Item dispensed and quantity, if applicable; and
3. Date of dispensing.

18 VAC 110-20-690. Persons or entities authorized or required to obtain a controlled substances registration.

A. A person or entity which maintains or intends to maintain a supply of Schedule II through Schedule VI controlled substances, other than manufacturers' samples, in order to administer such drugs in accordance with provisions of the Drug Control Act (§ 54.1-3400 et seq. of the Code of Virginia) may apply for a controlled substances registration on forms approved by the board.

B. Persons or entities which may be registered by the board shall include, but not be limited to, hospitals without in-house pharmacies, *nursing homes without in-house pharmacies that use automated drug dispensing systems*, ambulatory surgery centers, outpatient clinics, and emergency medical services agencies provided such persons or entities are otherwise authorized by law and hold required licenses or appropriate credentials to administer the drugs for which the registration is being sought.

C. In determining whether to register an applicant, the board shall consider factors listed in subsections A and D of § 54.1-3423 of the Code of Virginia and compliance with applicable requirements of this chapter.

D. The board may require a person or entity to obtain a controlled substances registration upon a determination that Schedule II through VI controlled substances have been obtained and are being used as common stock by multiple practitioners and that one or more of the following factors exist:

1. A federal, state, or local government agency has reported that the person or entity has made large purchases of controlled substances in comparison with other persons or entities in the same classification or category.
2. The person or entity has experienced a diversion, theft, or other unusual loss of controlled substances which requires reporting pursuant to § 54.1-3404 of the Drug Control Act.
3. The person or entity has failed to comply with recordkeeping requirements for controlled substances.
4. The person or entity or any other person with access to the common stock has violated any provision of federal, state, or local law or regulation relating to controlled substances.

18 VAC 110-20-700. Requirements for supervision for controlled substances registrants.

A. A practitioner licensed in Virginia shall provide supervision for all aspects of practice related to the maintenance and use of controlled substances as follows:

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1. In a hospital *or nursing home* without an in-house pharmacy, a pharmacist shall supervise.
2. In an emergency medical services agency, the operational medical director shall supervise.
3. For any other person or entity approved by the board, a practitioner of pharmacy, medicine, osteopathy, podiatry, dentistry, or veterinary medicine whose scope of practice is consistent with the practice of the person or entity and who is approved by the board shall provide the required supervision.

B. The supervising practitioner shall approve the list of drugs which may be ordered by the holder of the controlled substances registration; possession of controlled substances by the entity shall be limited to such approved drugs. The list of drugs approved by the supervising practitioner shall be maintained at the address listed on the controlled substances registration.

C. Access to the controlled substances shall be limited to the supervising practitioner or to those persons who are authorized by the supervising practitioner and who are authorized by law to administer drugs in Virginia or to other such persons as designated to have access in an emergency situation.

D. The supervising practitioner shall establish procedures for and provide training as necessary to ensure compliance with all requirements of law and regulation, including, but not limited to, storage, security, and recordkeeping.

18 VAC 110-20-710. Requirements for storage and security for controlled substances registrants.

A. Drugs shall be stored under conditions which meet USP-NF specifications or manufacturers' suggested storage for each drug.

B. Any drug which has exceeded the expiration date shall not be administered; it shall be separated from the stock used for administration and maintained in a separate, locked area until properly disposed.

C. If a controlled substances registrant wishes to dispose of unwanted or expired Schedule II through VI drugs, he shall transfer the drugs to another person or entity authorized to possess and to provide for proper disposal of such drugs.

D. Drugs shall be maintained in a lockable cabinet, cart, device or other area which shall be locked at all times when not in use. The keys or access code shall be restricted to the supervising practitioner and persons designated access in accordance with 18 VAC 110-20-700 C.

E. In a facility not staffed 24 hours a day, the drugs shall be stored in a fixed and secured room, cabinet or area which has a security device for the detection of breaking which meets the following conditions:

1. The device shall be a sound, microwave, photoelectric, ultrasonic, or any other generally accepted and suitable device.

2. The installation shall be hard wired and both the installation and device shall be based on accepted burglar alarm industry standards.

3. The device shall be maintained in operating order and shall have an auxiliary source of power.

4. The device shall fully protect all areas where prescription drugs are stored and shall be capable of detecting breaking by any means when activated.

5. Access to the alarm system shall be restricted to only designated and necessary persons, and the system shall be activated whenever the drug storage areas are closed for business.

6. *An alarm system is not required for researchers or animal control officers.*

VA.R. Doc. No. R03-26; Filed December 9, 2003, 3:02 p.m.

BOARD OF COUNSELING

Titles of Regulations: **18 VAC 115-20. Regulations Governing the Practice of Professional Counseling (amending 18 VAC 115-20-20, 18 VAC 115-20-100, 18 VAC 115-20-110, 18 VAC 115-20-140; adding 18 VAC 115-20-105, 18 VAC 115-20-106, 18 VAC 115-20-107).**

18 VAC 115-50. Regulations Governing the Practice of Marriage and Family Therapy (amending 18 VAC115-50-20, 18 VAC115-50-90, 18 VAC115-50-100, 18 VAC115-50-120; adding 18 VAC115-50-95, 18 VAC115-50-96, 18 VAC115-50-97).

18 VAC 115-60. Regulations Governing the Practice of Licensed Substance Abuse Treatment Practitioners (amending 18 VAC115-60-20, 18 VAC115-60-110, 18 VAC115-60-120, 18 VAC115-60-140; adding 18 VAC115-60-115, 18 VAC115-60-116, 18 VAC115-60-117).

Statutory Authority: § 54.1-103, 54.1-2400, and 54.1-3505.1 of the Code of Virginia.

Public Hearing Date: February 13, 2004 - 10 a.m.

Public comments may be submitted until February 27, 2004.
(See Calendar of Events section
for additional information)

Agency Contact: Elaine J. Yeatts, Agency Regulatory Coordinator, Department of Health Professions, 6603 West Broad Street, Richmond, VA 23230, telephone (804) 662-9918, FAX (804) 662-9114, or e-mail elaine.yeatts@dhp.state.va.us.

Basis: Chapter 430 of the 2002 Acts of Assembly adds § 54.1-3505.1 of the Code of Virginia, which mandates that the board establish requirements for evidence of continued competency as a condition of renewal of licenses.

In addition, the board is authorized under § 54.1-103 of the Code of Virginia to specify additional training or conditions for renewal of a license and under § 54.1-2400 of the Code of Virginia to generally regulate individuals seeking licensure.

Purpose: In developing the requirements, the board contemplated the financial and time burdens the requirements

might have on licensees, and at the same time strove to develop a meaningful standard that would assure continued competency to protect the public health, safety and welfare of people who receive counseling services from licensed practitioners.

Substance: In complying with the mandate to establish continuing competency requirements, the board has determined what types of education would be most meaningful for each of the licensure categories it regulates, while considering the cost and availability of education to licensees in a wide variety of practice situations in both metropolitan and rural areas of the state.

The statute also authorized the board to approve and register providers of continuing competency/education meeting certain criteria. The board had to determine the optimal method for ensuring the credibility of providers and the quality of their programs without increasing the cost and administrative burden of operating the licensure program.

The board adopted a proposed regulation setting forth an hour requirement, approved categories of activities, approved providers and instructions for documentation of compliance. The board has also included a provision for an inactive licensure status to allow practitioners who are not actively practicing professional counseling, marriage and family therapy, and substance abuse treatment in Virginia to defer the continuing competency requirement until they reactivate the license.

For alternatives the board considered the continuing education requirements of other state counseling boards, other professional counseling organizations and associations, as well as the requirements of other boards in the Department of Health Professions. The board also considered public comment regarding the content of the training. The board considered a range of hours from 10 to 40 per year, and selected 20 hours as a reasonable number of hours compared with the requirements in other states.

Issues:

The primary advantages and disadvantages to the public, such as individual private citizens or businesses, of implementing the new or amended provisions:

Since the public often relies on the professional judgment of professional counselors, marriage and family therapists, and substance abuse treatment practitioners continued education of practice would be advantageous to the public. There are no disadvantages to the public or to individual businesses, which are not affected by these regulations.

The primary advantages and disadvantages to the agency or the Commonwealth:

The fee structure set in regulation is intended to ensure that costs related to specific activities are borne by the applicants or certificate holders. Agencies of the Commonwealth that offer behavioral health assessment and treatment may benefit from having licensed providers who have more specific training for their job.

The board will incur additional costs to monitor compliance of licensees, and to hold additional disciplinary hearings for

individuals who do not comply with the requirement. With the passage of HB 1441 (2003 Session of the General Assembly) the board will be able to resolve some cases of noncompliance with a "Confidential Consent Agreement," thereby keeping the number of disciplinary proceedings low and the additional costs at reasonable limits.

Department of Planning and Budget's Economic Impact Analysis: The Department of Planning and Budget (DPB) has analyzed the economic impact of this proposed regulation in accordance with § 2.2-4007 H of the Administrative Process Act and Executive Order Number 21 (02). Section 2.2-4007 H requires that such economic impact analyses include, but need not be limited to, the projected number of businesses or other entities to whom the regulation would apply, the identity of any localities and types of businesses or other entities particularly affected, the projected number of persons and employment positions to be affected, the projected costs to affected businesses or entities to implement or comply with the regulation, and the impact on the use and value of private property. The analysis presented below represents DPB's best estimate of these economic impacts.

Summary of the proposed regulation. Pursuant to Chapter 430 of the 2002 Acts of the General Assembly, section § 54.1-3505.1 was added to the Code of Virginia. Section § 54.1-3505.1 obligates the Board of Professional Counseling (board) to "promulgate regulations establishing requirements for evidence of continued competency as a condition of renewal of a license" for the practice of counseling or marriage and family therapy or in the independent practice of substance abuse treatment. The board proposes to require that licensed professional counselors, marriage and family therapists, and substance abuse treatment practitioners complete a minimum of 20 hours of continuing competency activities each year in order to qualify for licensure renewal. The board also proposes to establish inactive licensure status. Additionally, the board seeks to require that counselors, therapists, and practitioners whose license has lapsed complete continuing competency hours prior to the reinstatement of their licenses.

Estimated economic impact. Continued Competency. Under the current regulations, licensed professional counselors, marriage and family therapists, and substance abuse treatment practitioners are not required to participate in continuing education activities. There is some evidence that many licensees participate in continuing education on their own accord.¹

According to the department, the fees for college courses and workshops offered by professional associations that address relevant content range from approximately \$10 to \$20 per contact hour. Licensees would also incur time and transportation expenses associated with traveling to and from

¹ As of June 13, 2003, 1,140 Virginia residents held the National Board for Certified Counselors' (NBCC) National Certified Counselor credential. NBCC certification requires 100 hours of continuing education during each five-year certification period. Thus, certificate-holders will average at least 20 hours of continuing education per year. Not all certificate-holders are licensed. NBCC does not track the licensure status of its certificate-holders. Presumably though, a significant percentage of certificate-holders do practice and hold licensure. These individuals will already meet or come close to meeting the board's proposed requirement of 20 hours of continuing education per year.

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the locations of the workshops and courses. Online courses that would qualify for continuing competency, which do not have associated traveling expenses, are available for about \$10 per hour.²

In addition to fees, the time of counselors, therapists, and practitioners also has value. The mean hourly wages for licensed professional counselors, marriage and family therapists, and substance abuse treatment practitioners in Virginia are \$14.34, \$15.03, and \$17.86, respectively.³ Assuming that the value of a licensee's time is equal to her mean hourly wage, and that the licensee would seek to minimize costs by taking online courses, then it will cost licensed professional counselors, marriage and family therapists, and substance abuse treatment practitioners approximately \$24.34,⁴ \$25.03,⁵ and \$27.86,⁶ respectively, for each additional hour of continuing competency activity incurred in order to meet the proposed requirement. For licensees who without the proposed requirement would not participate in any continuing competency activity, compliance will cost approximately \$486.80,⁷ \$500.06,⁸ and \$557.20,⁹ respectively, for counselors, therapists, and practitioners. This does not include the cost of transportation for licensees.

There are 3,663 persons licensed as either a professional counselor, marriage and family therapist, or substance abuse treatment practitioners in the Commonwealth.¹⁰ Neither the department nor the National Board for Certified Counselors has an estimate of how many professional counselors, marriage and family therapist, or substance abuse treatment practitioners in Virginia currently take continuing education courses. Hypothetically, if without the proposed requirement one-third of licensees would take zero hours of continuing education per year and the other two-thirds of licensees would take at least 20 hours of continuing education per year, then the proposed 20-hour per annum continuing education requirement will cost licensees on the order of \$601,000¹¹. If instead two-thirds of licensees would take zero hour of continuing education per year and the other one-third of licensees would take at least 20 hours of continuing education per year, then the proposed 20-hour per annum continuing

education requirement will cost licensees something around \$1,203,000¹².

The benefit of the proposed continuing competency activity requirement is more difficult to estimate than the cost. Since the continuing competency hours must be spent on field-related topics, licensees who participate likely gain some useful knowledge. That said, it is important to note that, strictly speaking, evidence of the completion of continuing education classes is not direct evidence of competency but is rather a distant proxy. Without some indication of how much information was assimilated by the licensee and how that information relates to the licensee's actual practice, it is not valid to assume that the mere exposure to coursework in an area is a good signal of competency. While a written competency test may itself be an imperfect instrument for measuring fluency with a subject matter, a test is bound to be a better measure of actual knowledge than mere evidence of having attended a lecture or having viewed a videotaped program.

Furthermore, using continuing education as a proxy for continued competence is very likely to be economically wasteful. Those who have little difficulty staying up-to-date through their other activities are required to take unnecessary classes to satisfy competency requirements that they could easily demonstrate by taking a test. Those who do not learn much from continuing education classes will nonetheless be licensed to continue practice in spite of having skills that may be considered inadequate by the board. In the latter case, the expenditure on the class would be unproductive, plus it would facilitated the continued practice of someone lacking minimally acceptable competency.

No one should be under the impression that a continuing education requirement actually ensures that licensees under this board maintain continued competency. Many will do so without the requirement, and many will not do so in spite of the requirement.

Inactive licensure. The board proposes to establish inactive licensure status. From the proposed regulations, "A licensee who wishes to place his license in an inactive status may do so upon payment of the inactive renewal fee ... No person shall practice counseling in Virginia unless he holds a current active license." Licensees in inactive status pay a lower annual fee than active licensees, \$55 rather than \$105, and are not required to participate in continuing competency activity. However, as the status name indicates, inactive licensees may not practice while their license is in inactive status. In order to reactivate an inactive license, the licensee must complete 20 continuing competency hours for each year the license has been inactive, not to exceed a maximum of 80 hours.

The inactive license may be attractive to some licensees who plan on not practicing for one or two years. The inactive licensee will save \$50 a year in fees¹³ compared to the active

² According to the Department of Health Professions, online classes from the Healthcare Training Institute that cost \$45 for a four-hour course, \$65 for a six-hour course, and \$85 for a ten-hour course, are typical of the types of classes that would qualify for continuing competency hours.

³ Source: U.S. Department of Labor, Bureau of Labor Statistics, 2001 State Occupational Employment and Wage Estimates

⁴ Calculation: \$10 (course fee per hour) + \$14.34 (value of one hour of time) = \$24.34

⁵ Calculation: \$10 (course fee per hour) + \$15.03 (value of one hour of time) = \$25.03

⁶ Calculation: \$10 (course fee per hour) + \$17.86 (value of one hour of time) = \$27.86

⁷ Calculation: 20 x \$10 = \$200 in course fees; 20 x \$14.34 = \$286.80 for value of time; \$200 + \$286.80 = \$486.80 for total cost

⁸ Calculation: 20 x \$10 = \$200 in course fees; 20 x \$15.03 = \$300.60 for value of time; \$200 + \$300.60 = \$500.60 for total cost

⁹ Calculation: 20 x \$10 = \$200 in course fees; 20 x \$17.86 = \$357.20 for value of time; \$200 + \$357.20 = \$557.20 for total cost

¹⁰ Source: According to the Department of Health Professions, there are 2,653 persons licensed as professional counselors, 871 persons licensed as marriage and family therapists, and 139 persons licensed as substance abuse treatment practitioners in Virginia. Calculation: 2,653 + 871 + 139 = 3,663

¹¹ Calculation: 1/3 x ((\$486.80 x 2,653) + (\$500.06 x 871) + (\$557.20 x 139)) = \$601,494.49

¹² Calculation: 2/3 x ((\$486.80 x 2,653) + (\$500.06 x 871) + (\$557.20 x 139)) = \$1,202,988.97

¹³ Calculation: \$105 (active fee) - \$55 (inactive fee) = \$50

licensee, and will have greater choice as to when to take continuing competency courses.

Licensees who plan not to practice for three or more years will likely prefer to let their license lapse, rather than pay inactive license fees. In order to reactivate a lapsed license, the individual must complete continuing competency hours equal to the number of years the license has been inactive, not to exceed a maximum of 80 hours; this is identical to the requirement for reactivating an inactive license. The fee for reinstatement of a lapsed license is \$165. Three years of inactive licensure fees total \$165.¹⁴ Given that the total fees paid are equal, and that inactive licensure fees are paid earlier than the reinstatement fee, most individuals who plan to not practice for three years would likely let their license lapse rather than choose inactive licensure. Individuals who plan not to practice for four or more years are even more likely to choose to let their license lapse rather than pay for inactive licensure since the total amount of the fees for inactive licensure will be greater than the lapsed license reactivation fee,¹⁵ and payment of the fee occurs later than the payments for inactive licensure fees.

Businesses and entities affected. The proposed amendments affect the 2,653 persons licensed as professional counselors, the 871 persons licensed as marriage and family therapists, the 139 persons licensed as substance abuse treatment practitioners, their patients, and employers and potential employers, their patients and potential patients, as well as colleges, professional associations and other entities that offer continuing competence courses.

Localities particularly affected. The proposed regulations affect all Virginia localities.

Projected impact on employment. The proposed amendments will likely increase demand for continuing competence courses. Consequently, there may be a small increase in employment for providers of these courses.

Effects on the use and value of private property. The proposal to require 20 hours of continuing competence activity every year will increase demand for continuing competence courses. Consequently, the aggregate value of providers of these courses will increase.

Agency's Response to the Department of Planning and Budget's Economic Impact Analysis: Section 54.1-3505 of the Code of Virginia obligates the Board of Counseling to "promulgate regulations establishing requirements for evidence of continued competency as a condition of renewal of a license." In proceeding with this effort there were a number of things that the board considered:

1. Continuing competency requirements for license renewal in other states as well as what is considered the national standard set by the profession for continued competence. The 20 hours required by the proposed regulation are well within the parameters of what other licensing boards require and meets the national standard.

¹⁴ Calculation: $\$55 \times 3 = \165

¹⁵ Four years of inactive licensure: $\$55 \times 4 = \220 ; five years of inactive licensure: $\$55 \times 5 = \275 ; six years of inactive licensure: $\$55 \times 6 = \330 , etc.

2. Hardship for licensee to obtain the twenty hours. The board recognized that the counseling profession is broad and that licensees have a wide variety of interests in the pursuit of additional training. We were also cognizant that complications of life and work situations might make obtaining these hours more difficult for some licensees. While structured coursework with some sort of examination might be the best way to assure that learning has taken place, much training in our profession has always been done in other venues such as workshops, group supervision, and other experiential formats etc. that do not have an examination component, but do provide professional with important learning experiences. By allowing for a large range of both face to face and on-line activities, we feel that licensees will have the greatest ability to tailor learning to areas that interest them and therefore will be more likely to have meaning for their professional practice without unnecessary hardship for their personal lives.

3. Financial hardship. Throughout the open board meeting process of deciding on these proposed regulations, as well as the public comment periods, both licensees as well as their professional organizations, have had the opportunity to comment on this proposal. As these are the individuals who would be most financially impacted, we would expect any concern to have come to the board's attention. As the number of proposed hours is considered to be the national standard by the profession, there has been no negative comment. Most committed professional who are practicing are probably already obtaining these continued education hours for other certifications, and there will not be any additional financial impact for them

4. Inactive Licensure. The purpose of inactive licensure is to provide some additional options to those licensees who, due to life situations and circumstances, are suspending their practice for a short window of time with the intention of returning to practice. This option lessens the financial burden of license renewal fees during that time period they are not practicing. This new option will allow licensees to choose which option (inactive status or not renewing) best meets their personal needs at the time. At the same time, the continued competency requirement for reactivation gives some assurance to the board that the same level of continued professional education has been met as other licensees.

Summary:

The proposed amendments (i) require that licensed professional counselors, marriage and family therapists, and substance abuse treatment practitioners complete a minimum of 20 hours of continuing competency activities each year in order to qualify for licensure renewal; (ii) provide for an inactive licensure status for individuals who are not actively practicing and may be unable to meet the continuing competency requirements; and (iii) require that a counselor, therapist, or practitioner whose license has lapsed complete continuing competency hours prior to reinstatement of his license.

18 VAC 115-20-20. Fees required by the board.

A. The board has established the following fees applicable to licensure as a professional counselor:

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Active annual license renewal	\$105
Inactive annual license renewal	\$55
Initial licensure by examination	\$65
Initial licensure by endorsement	\$65
Duplicate license	\$5
Verification of licensure to another jurisdiction	\$25
Late renewal	\$35
Reinstatement of a lapsed license	\$165
Replacement of or additional wall certificate	\$15
Returned check	\$25
Reinstatement following revocation or suspension	\$500

B. Fees shall be paid to the board or its contractor or both in appropriate amounts as specified in the application instructions. All fees are nonrefundable.

C. Examination fees shall be determined and made payable as determined by the board.

18 VAC 115-20-100. Annual renewal of licensure.

A. All licensees shall renew licenses on or before June 30 of each year.

B. *Beginning with the 2005 renewal*, every license holder who intends to continue to an active practice shall submit to the board on or before June 30 of each year:

1. A completed application for renewal of the license on which the licensee attests to compliance with the continuing competency requirements prescribed in this chapter; and
2. The renewal fee prescribed in 18 VAC 115-20-20.

C. A licensee who wishes to place his license in an inactive status may do so upon payment of the inactive renewal fee as established in 18 VAC 115-20-20. No person shall practice counseling in Virginia unless he holds a current active license. A licensee who has placed himself in inactive status may become active by fulfilling the reactivation requirements set forth in 18 VAC 115-20-110 C.

D. Licensees shall notify the board of change of address within 60 days. Failure to receive a renewal notice from the board shall not relieve the license holder from the renewal requirement.

18 VAC 115-20-105. Continued competency requirements for renewal of a license.

A. After July 1, 2004, licensed professional counselors shall be required to have completed a minimum of 20 hours of continuing competency for each annual licensure renewal. A minimum of two of these hours shall be in courses that emphasize the ethics, standards of practice or laws governing behavioral science professions in Virginia.

B. The board may grant an extension for good cause of up to one year for the completion of continuing competency requirements upon written request from the licensee prior to the renewal date. Such extension shall not relieve the licensee of the continuing competency requirement.

C. The board may grant an exemption for all or part of the continuing competency requirements due to circumstances

beyond the control of the licensee such as temporary disability, mandatory military service, or officially declared disasters.

D. Those individuals dually licensed by this board will not be required to obtain continuing competency for each license. Dually licensed individuals will only be required to provide the hours set out in subsection A of this section or subsection A of 18 VAC 115-50-95 in the Regulations Governing the Practice of Marriage and Family Therapy, or subsection A of 18 VAC 115-60-115 in the Regulations Governing the Practice of Licensed Substance Abuse Treatment Practitioners.

18 VAC 115-20-106. Continuing competency activity criteria.

A. Continuing competency activities must focus on increasing knowledge or skills in one or more of the following areas:

1. Ethics, standards of practice or laws governing behavioral science professions;
2. Counseling theory;
3. Human growth and development;
4. Social and cultural foundations;
5. The helping relationship;
6. Group dynamics, processing and counseling;
7. Lifestyle and career development;
8. Appraisal of individuals;
9. Research and evaluation;
10. Professional orientation;
11. Clinical supervision;
12. Marriage and family therapy; or
13. Addictions.

B. Approved hours of continuing competency activity shall be one of the following types:

1. Formally organized learning activities or home study. Activities may be counted at their full hour value. Hours shall be obtained from one or a combination of the following board-approved, mental health-related activities:
 - a. Regionally accredited university or college level academic courses in a behavioral health discipline.
 - b. Continuing education programs offered by universities or colleges.
 - c. Workshops, seminars, conferences, or courses in the behavioral health field offered by federal, state or licensed health facilities and licensed hospitals.
 - d. Workshops, seminars, conferences or courses in the behavioral health field offered by an individual or organization that has been certified or approved by one of the following:
 - (1) The American Association of Marriage and Family Counselors and its state affiliates.

(2) *The American Association of Marriage and Family Therapists and its state affiliates.*

(3) *The American Association of State Counseling Boards.*

(4) *The American Counseling Association and its state and local affiliates.*

(5) *The American Psychological Association and its state affiliates.*

(6) *Commission on Rehabilitation Education.*

(7) *NAADAC, The Association for Addiction Professionals and its state and local affiliates.*

(8) *National Association of Social Workers.*

(9) *National Board for Certified Counselors.*

(10) *A national behavioral health organization or certification body.*

(11) *Individuals or organizations that have been approved as continuing competency sponsors by the American Association of State Counseling Boards or a counseling board in another state.*

2. Individual professional activities.

a. Publication/presentation/new program development.

(1) *Publication of articles. Activity will count for a maximum of eight hours. Publication activities are limited to articles in refereed journals or a chapter in an edited book.*

(2) *Publication of books. Activity will count for a maximum of 18 hours.*

(3) *Presentations. Activity will count for a maximum of eight hours. The same presentations may be used only once in a two-year period. Only actual presentation time may be counted.*

(4) *New program development Activity will count for a maximum of eight hours. New program development includes a new course, seminar, or workshop. New courses shall be graduate or undergraduate level college or university courses.*

b. *Dissertation. Activity will count for a maximum of 18 hours. Dissertation credit may only be counted once.*

c. *Clinical supervision/consultation. Activity will count for a maximum of ten hours. Continuing competency can only be granted for clinical supervision/consultation received on a regular basis with a set agenda. Continuing competency cannot be granted for supervision that you provide to others.*

d. *Leadership. Activity will count for a maximum of eight hours. The following leadership positions are acceptable for continuing competency credit: officers of state or national counseling organization; editor and/or reviewer of professional counseling journals; member of state counseling licensure/certification board; member of a national counselor certification board; member of a*

national ethics disciplinary review committee rendering licenses; active member of a counseling committee producing a substantial written product; chair of a major counseling conference or convention; other leadership positions with justifiable professional learning experiences. The leadership positions must take place for a minimum of one year after the date of first licensure.

e. *Practice related programs. Activity will count up to a maximum of eight hours. The board may allow up to eight contact hours of continuing competency as long as the regulant submits proof of attendance plus a written justification of how the activity assists him in his direct service of his clients. Examples include language courses, software training, medical topics, etc.*

18 VAC 115-20-107. Documenting compliance with continuing competency requirements.

A. *All licensees are required to maintain original documentation for a period of two years following renewal.*

B. *After the end of each renewal period, the board may conduct a random audit of licensees to verify compliance with the requirement for that renewal period.*

C. *Upon request, a licensee shall provide documentation as follows:*

1. *To document completion of formal organized learning activities, the licensee shall provide:*

- a. *Official transcripts showing credit hours earned; or*
- b. *Certificates of participation.*

2. *Documentation of home study shall be made by identification of the source material studied, summary of content, and a signed affidavit attesting to completion of the home study.*

3. *Documentation of individual professional activities shall be by one of the following:*

- a. *Certificates of participation;*
- b. *Proof of presentations made;*
- c. *Reprints of publications;*
- d. *Letters from educational institutions or agencies approving continuing education programs;*
- e. *Official notification from the association that sponsored the item writing workshop or continuing education program; or*
- f. *Documentation of attendance at formal staffing by a signed affidavit on a form provided by the board.*

D. *Continuing competency hours required by a disciplinary order shall not be used to satisfy renewal requirements.*

18 VAC 115-20-110. Late renewal; reinstatement.

A. *A person whose license has expired may renew it within one year after its expiration date by paying the late fee prescribed in 18 VAC 115-20-20 as well as the license renewal fee prescribed for the year the license was not*

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renewed and providing evidence of having met all applicable continuing competency requirements.

B. A person who fails to renew a license after one year or more and wishes to resume practice shall apply for reinstatement, pay the reinstatement fee for a lapsed license and , submit evidence regarding the continued ability to perform the functions within the scope of practice of the license, and provide evidence of having met all applicable continuing competency requirements not to exceed a maximum of 80 hours.

C. A person wishing to reactivate an inactive license shall submit (i) the renewal fee for active licensure minus any fee already paid for inactive licensure renewal and (ii) documentation of continued competency hours equal to the number of years the license has been inactive not to exceed a maximum of 80 hours.

18 VAC 115-20-140. Grounds for revocation, suspension, probation, reprimand, censure, or denial of renewal of license.

A. Action by the board to revoke, suspend or decline to renew a license may be taken in accord with the following:

1. Conviction of a felony, or of a misdemeanor involving moral turpitude, or violation of or aid to another in violating any provision of Chapter 35 (§ 54.1-3500 et seq.) of Title 54.1 of the Code of Virginia, any other statute applicable to the practice of professional counseling, or any provision of this chapter.
2. Procuring of license by fraud or misrepresentation.
3. Conducting one's practice in such a manner as to make it a danger to the health and welfare of one's clients or to the public, or if one is unable to practice counseling with reasonable skill and safety to clients by reason of illness, abusive use of alcohol, drugs, narcotics, chemicals, or other type of material or result of any mental or physical condition.
4. Negligence in professional conduct or nonconformance with the Standards of Practice (18 VAC 115-20-130 B).
5. Performance of functions outside the demonstrable areas of competency.
6. Failure to comply with the continued competency requirements set forth in this chapter.

B. Following the revocation or suspension of a license, the licensee may petition the board for reinstatement upon good cause shown or as a result of substantial new evidence having been obtained that would alter the determination reached.

NOTICE: The forms used in administering 18 VAC 115-20, Regulations Governing the Practice of Professional Counseling, are listed below. Any amended or added forms are reflected in the listing and are published following the listing.

FORMS

License Renewal Notice and Application (rev. ~~2/00~~ 11/03).

~~Quarterly Evaluation Form (eff. 2/00).~~

~~Verification of Supervision Form (eff. 2/00).~~

~~Registration of Supervision; Post Graduate Degree Supervised Experience (eff. 2/00).~~

~~Application for Reinstatement of a Lapsed License (eff. 11/03).~~

18 VAC 115-50-20. Fees.

A. The board has established fees for the following:

Registration of supervision	\$50
Add or change supervisor	\$25
Initial licensure by examination: Processing and initial licensure	140
Initial licensure by endorsement: Processing and initial licensure	\$140
Active annual license renewal	\$105
Inactive annual license renewal	\$55
Penalty for late renewal	\$35
Reinstatement of a lapsed license	\$165
Verification of license to another jurisdiction	\$25
Additional or replacement licenses	\$5
Additional or replacement wall certificates	\$15
Returned check	\$25
Reinstatement following revocation or suspension	\$500

B. Fees shall be paid to the board or its contractor or both in appropriate amounts as specified in the application instructions. All fees are nonrefundable.

C. Examination fees shall be determined and made payable as determined by the board.

18 VAC 115-50-90. Annual renewal of license.

A. All licensees shall renew licenses on or before June 30 of each year.

B. ~~Beginning with the 2005 renewal~~, all licensees who intend to continue to an active practice shall submit to the board on or before the expiration date of the license submit to the board June 30 of each year:

1. A license renewal application supplied by the board completed application for renewal of the license on which the licensee attests to compliance with the continuing competency requirements prescribed in this chapter; and
2. The renewal fee prescribed in 18 VAC 115-50-20.

C. A licensee who wishes to place his license in an inactive status may do so upon payment of the inactive renewal fee as established in 18 VAC 115-50-20. No person shall practice marriage and family therapy in Virginia unless he holds a current active license. A licensee who has placed himself in inactive status may become active by fulfilling the reactivation requirements set forth in 18 VAC 115-50-100 C.

~~G. D.~~ Licensees shall notify the board of change of address within 60 days. Failure to receive a renewal notice from the board shall not relieve the license holder from the renewal requirement.

~~D. Licensees shall provide the board with official documentation of a legal name change and written notification of address changes within 90 days of such change.~~

18 VAC 115-50-95. Continued competency requirements for renewal of a license.

A. After July 1, 2004, marriage and family therapists shall be required to have completed a minimum of 20 hours of continuing competency for each annual licensure renewal. A minimum of two of these hours shall be in courses that emphasize the ethics, standards of practice or laws governing behavioral science professions in Virginia.

B. The board may grant an extension for good cause of up to one year for the completion of continuing competency requirements upon written request from the licensee prior to the renewal date. Such extension shall not relieve the licensee of the continuing competency requirement.

C. The board may grant an exemption for all or part of the continuing competency requirements due to circumstances beyond the control of the licensee such as temporary disability, mandatory military service, or officially declared disasters.

D. Those individuals dually licensed by this board will not be required to obtain continuing competency for each license. Dually licensed individual will only be required to provide the hours set out in subsection A of this section or subsection A of 18 VAC 115-20-105 in the Regulations Governing the Practice of Professional Counseling, or subsection A of 18 VAC 115-60-115 in the Regulations Governing the Practice of Licensed Substance Abuse Treatment Practitioners.

18 VAC 115-50-96. Continuing competency activity criteria.

A. Continuing competency activities must focus on increasing knowledge or skills in one or more of the following areas:

1. Ethics, standards of practice or laws governing behavioral science professions;
2. Counseling theory;
3. Human growth and development;
4. Social and cultural foundations;
5. The helping relationship;
6. Group dynamics, processing and counseling;
7. Lifestyle and career development;
8. Appraisal of individuals;
9. Research and evaluation;
10. Professional orientation;
11. Clinical supervision;
12. Marriage and family therapy; or
13. Addictions.

B. Approved hours of continuing competency activity shall be one of the following types:

1. Formally organized learning activities or home study. Activities may be counted at their full hour value. Hours shall be obtained from one or a combination of the following board-approved, mental health-related activities:

- a. Regionally accredited university or college level academic courses in a behavioral health discipline.
- b. Continuing education programs offered by universities or colleges.
- c. Workshops, seminars, conferences, or courses in the behavioral health field offered by federal, state or local licensed health facilities and licensed hospitals.
- d. Workshops, seminars, conferences or courses in the behavioral health field offered by an individual or organization that has been certified or approved by one of the following:

(1) The American Association of Marriage and Family Counselors and its state affiliates.

(2) The American Association of Marriage and Family Therapists and its state affiliates.

(3) The American Association of State Counseling Boards.

(4) The American Counseling Association and its state and local affiliates.

(5) The American Psychological Association and its state affiliates.

(6) Commission on Rehabilitation Education.

(7) NAADAC, The Association for Addiction Professionals. and its state and local affiliates.

(8) National Association of Social Workers.

(9) National Board for Certified Counselors.

(10) A national behavioral health organization or certification body.

(11) Individuals or organizations that have been approved as continuing competency sponsors by the American Association of State Counseling Boards or a counseling board in another state.

2. Individual professional activities.

a. Publication/presentation/new program development.

(1) Publication of articles. Activity will count for a maximum of eight hours. Publication activities are limited to articles in refereed journals or a chapter in an edited book.

(2) Publication of books. Activity will count for a maximum of 18 hours.

(3) Presentations. Activity will count for a maximum of eight hours. The same presentations may be used only once in a two-year period. Only actual presentation time may be counted.

(4) New program development activity will count for a maximum of eight hours. New program development

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includes a new course, seminar, or workshop. New courses shall be graduate or undergraduate level college or university courses.

b. *Dissertation.* Activity will count for a maximum of 18 hours. Dissertation credit may only be counted once.

c. *Clinical supervision/consultation.* Activity will count for a maximum of ten hours. Continuing competency can only be granted for clinical supervision/consultation received on a regular basis with a set agenda. Continuing competency cannot be granted for supervision that you provide to others.

d. *Leadership.* Activity will count for a maximum of eight hours. The following leadership positions are acceptable for continuing competency credit: officers of state or national counseling organization; editor and/or reviewer of professional counseling journals; member of state counseling licensure/certification board; member of a national counselor certification board; member of a national ethics disciplinary review committee rendering licenses; active member of a counseling committee producing a substantial written product; chair of a major counseling conference or convention; other leadership positions with justifiable professional learning experiences. The leadership positions must take place for a minimum of one year after the date of first licensure.

e. *Practice related programs.* Activity will count up to a maximum of eight hours. The board may allow up to eight contact hours of continuing competency as long as the regulant submits proof of attendance plus a written justification of how the activity assists him in his direct service of his clients. Examples include language courses, software training, medical topics, etc.

18 VAC 115-50-97. Documenting compliance with continuing competency requirements.

A. All licensees are required to maintain original documentation for a period of two years following renewal.

B. After the end of each renewal period, the board may conduct a random audit of licensees to verify compliance with the requirement for that renewal period.

C. Upon request, a licensee shall provide documentation as follows:

1. To document completion of formal organized learning activities, licensee shall provide:

- a. Official transcripts showing credit hours earned; or
- b. Certificates of participation.

2. Documentation of home study shall be made by identification of the source material studied, summary of content, and a signed affidavit attesting to completion of the home study.

3. Documentation of individual professional activities shall be by one of the following:

- a. Certificates of participation;
- b. Proof of presentations made;

c. Reprints of publications;

d. Letters from educational institutions or agencies approving continuing education programs;

e. Official notification from the association that sponsored the item writing workshop or continuing education program; or

f. Documentation of attendance at formal staffing shall be by signed affidavit on a form provided by the board.

D. Continuing competency hours required by a disciplinary order shall not be used to satisfy renewal requirements.

18 VAC 115-50-100. Late renewal, reinstatement.

A. ~~An individual~~ A person whose license has expired may renew it within one year after its expiration date by paying the penalty fee prescribed in 18 VAC 115-50-20 as well as the license fee prescribed for the period the license was not renewed and providing evidence of having met all applicable continuing competency requirements.

B. ~~An individual~~ A person seeking reinstatement of a license one year or more after its expiration date must apply for reinstatement, pay the reinstatement fee and , submit evidence regarding the continued ability to perform the functions within the scope of practice of the license, and provide evidence of having met all applicable continuing competency requirements not to exceed a maximum of 80 hours.

C. A person wishing to reactivate an inactive license shall submit (i) the renewal fee for active licensure minus any fee already paid for inactive licensure renewal and (ii) documentation of continued competency hours equal to the number of years the license has been inactive, not to exceed a maximum of 80 hours.

18 VAC 115-50-120. Disciplinary action.

In accordance with § 54.1-2400 of the Code of Virginia, the board may, after a hearing, revoke, suspend or decline to issue or renew a license or impose a fine in accordance with the following:

1. Conviction of a felony or of a misdemeanor involving moral turpitude;
2. Procurement of a license, certificate or registration by fraud or misrepresentation;
3. Conducting one's practice in such a manner as to make it a danger to the health and welfare of one's clients or the general public;
4. Practicing marriage and family therapy without reasonable skill and safety to clients by virtue of physical or emotional illness, abusive use of alcohol, drugs, narcotics, chemicals or any other hazardous substance or material;
5. Providing or offering services outside the demonstrable areas of competency; or
6. Violating or abetting another person in the violation of any provision of any statute applicable to the practice of

marriage and family therapy, or any part or portion of this chapter; or

7. Failure to comply with the continued competency requirements set forth in this chapter.

NOTICE: The forms used in administering 18 VAC 115-50, Regulations Governing the Practice of Marriage and Family Therapy, are not being published due to the large number; however, the name of each form is listed below. The forms are available for public inspection at the Department of Health Professions, 6603 W. Broad Street, Richmond, Virginia, or at the office of the Registrar of Regulations, General Assembly Building, 2nd Floor, Richmond, Virginia.

FORMS

Marriage and Family Therapist Licensure Application, ~~MFTAPP4~~ Form 1 (rev. ~~2/00~~ 11/03).

Licensure Verification of Applicant, ~~MFTAPP2~~ Form 2 (rev. ~~7/99~~ 11/03).

Verification of Supervision for Marriage and Family Therapist Licensure, ~~MFTAPP3~~ Form 3 (rev. ~~7/99~~ 11/03).

~~Quarterly Evaluation Form, MFTAPP 3B (eff. 8/99).~~

Licensure Verification of Out-of-State Supervisor, ~~MFTAPP4~~ Form 4 (rev. ~~7/99~~ 11/03).

Courses Outline Form for Marriage and Family Therapist Licensure, ~~MFTAPP5~~ Form 5 (eff. ~~7/97~~ rev. 11/03).

Verification of Internship, ~~MFTAPP6~~ Form 6 (eff. ~~8/99~~ rev. 11/03).

Verification of Internship Hours Toward the Residency, ~~MFTAPP7~~ Form 7 (eff. ~~8/99~~ rev. 11/03).

Supervision Outline Form for Marriage and Family Endorsement Applicants, Form 8 (rev. 11/03).

Registration of Supervision for Marriage and Family Therapist Licensure, ~~MFTREG4~~ Form A (rev. ~~2/00~~ 11/03).

Application for Reinstatement of a Lapsed License (eff. 11/03).

General Information for Licensure as a Marriage and Family Therapist (eff. 11/03).

Application Instructions - Licensure by Examination (eff. 11/03).

Application Instructions - Licensure by Endorsement (eff. 11/03).

License Renewal Notice and Application (rev. ~~2/00~~ 11/03).

~~Supervision Outline Form for Marriage and Family Therapist Endorsement Applicants, MFTAPP8 (eff. 12/99).~~

18 VAC 115-60-20. Fees required by the board.

A. The board has established the following fees applicable to licensure as a substance abuse treatment practitioner:

Registration of supervision (initial)	\$50
Add/change supervisor	\$25

Initial licensure by examination: Processing and initial licensure	\$140
Initial licensure by endorsement: Processing and initial licensure	\$140
Active annual license renewal	\$105
Inactive annual license renewal	\$55
Duplicate license	\$5
Verification of license to another jurisdiction	\$25
Late renewal	\$35
Reinstatement of a lapsed license	\$165
Replacement of or additional wall certificate	\$15
Returned check	\$25
Reinstatement following revocation or suspension	\$500

B. Fees shall be paid *directly* to the board or its contractor, or both, in appropriate amounts as specified in the application instructions. All fees are nonrefundable.

C. Examination fees shall be determined and made payable as determined by the board.

18 VAC 115-60-110. Renewal of licensure.

A. All licensees shall renew licenses on or before June 30 of each year.

B. *Beginning with the 2005 renewal*, every license holder who intends to continue to an active practice shall submit to the board on or before June 30 of each year:

1. A completed application for renewal of the license on which the licensee attests to compliance with the continuing competency requirements prescribed in this chapter; and
2. The renewal fee prescribed in 18 VAC 115-60-20.

C. *A licensee who wishes to place his license in an inactive status may do so upon payment of the inactive renewal fee as established in 18 VAC 115-60-20. No person shall practice substance abuse treatment in Virginia unless he holds a current active license. A licensee who has placed himself in inactive status may become active by fulfilling the reactivation requirements set forth in 18 VAC 115-60-120 C.*

~~G. D.~~ Licensees shall notify the board of a change of address within 60 days. Failure to receive a renewal notice from the board shall not relieve the license holder from the renewal requirement.

18 VAC 115-60-115. Continued competency requirements for renewal of a license.

A. *After July 1, 2004, licensed substance abuse treatment practitioners shall be required to have completed a minimum of 20 hours of continuing competency for each annual licensure renewal. A minimum of two of these hours shall be in courses that emphasize the ethics, standard of practice or laws governing behavioral science professions in Virginia.*

B. *The board may grant an extension for good cause of up to one year for the completion of continuing competency requirements upon written request from the licensee prior to the renewal date. Such extension shall not relieve the licensee of the continuing competency requirement.*

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C. The board may grant an exemption for all or part of the continuing competency requirements due to circumstances beyond the control of the licensee, such as temporary disability, mandatory military service, or officially declared disasters.

D. Those individuals dually licensed by this board will not be required to obtain continuing competency for each license. Dually licensed individuals will only be required to provide the hours set out in subsection A of this section or subsection A of 18 VAC 115-50-95 in the Regulations Governing the Practice of Marriage and Family Therapy, or subsection A of 18 VAC 115-20-115 in the Regulations Governing the Practice of Professional Counseling.

18 VAC 115-60-116. Continuing competency activity criteria.

A. Continuing competency activities must focus on increasing knowledge or skills in one or more of the following areas:

1. Ethics, standards of practice or laws governing behavioral science professions;
2. Counseling theory;
3. Human growth and development;
4. Social and cultural foundations;
5. The helping relationship;
6. Group dynamics, processing and counseling;
7. Lifestyle and career development;
8. Appraisal of individuals;
9. Research and evaluation;
10. Professional orientation;
11. Clinical supervision;
12. Marriage and family therapy; or
13. Addictions.

B. Approved hours of continuing competency activity shall be one of the following types:

1. Formally organized learning activities or home study. Activities may be counted at their full hour value. Hours shall be obtained from one or a combination of the following board-approved, mental health-related activities:

- a. Regionally accredited university-or college-level academic courses in a behavioral health discipline.
- b. Continuing education programs offered by universities or colleges.
- c. Workshops, seminars, conferences, or courses in the behavioral health field offered by federal, state or licensed health facilities and licensed hospitals.
- d. Workshops, seminars, conferences or courses in the behavioral health field offered by an individual or organization that has been certified or approved by one of the following:

(1) The American Association of Marriage and Family Counselors and its state affiliates.

(2) The American Association of Marriage and Family Therapists and its state affiliates.

(3) The American Association of State Counseling Boards.

(4) The American Counseling Association and its state and local affiliates.

(5) The American Psychological Association and its state affiliates.

(6) Commission on Rehabilitation Education.

(7) NAADAC, The Association for Addiction Professionals, and its state and local affiliates.

(8) National Association of Social Workers.

(9) The National Board for Certified Counselors.

(10) A national behavioral health organization or certification body.

(11) Individuals or organizations that have been approved as continuing competency sponsors by the American Association of State Counseling Boards or a counseling board in another state.

2. Individual professional activities.

a. Publication/presentation/new program development.

(1) Publication of articles. Activity will count for a maximum of eight hours. Publication activities are limited to articles in refereed journals or a chapter in an edited book.

(2) Publication of books. Activity will count for a maximum of 18 hours.

(3) Presentations. Activity will count for a maximum of eight hours. The same presentations may be used only once in a two-year period. Only actual presentation time may be counted.

(4) New program development. Activity will count for a maximum of eight hours. New program development includes a new course, seminar, or workshop. New courses shall be graduate or undergraduate level college or university courses.

b. Dissertation. Activity will count for a maximum of 18 hours. Dissertation credit may only be counted once.

c. Clinical supervision/consultation. Activity will count for a maximum of 10 hours. Continuing competency can only be granted for clinical supervision/consultation received on a regular basis with a set agenda. Continuing competency cannot be granted for supervision that you provide to others.

d. Leadership. Activity will count for a maximum of eight hours. The following leadership positions are acceptable for continuing competency credit: officers of state or national counseling organization; editor and/or reviewer of professional counseling journals; member of state

counseling licensure/certification board; member of a national counselor certification board; member of a national ethics disciplinary review committee rendering licenses; active member of a counseling committee producing a substantial written product; chair of a major counseling conference or convention; other leadership positions with justifiable professional learning experiences. The leadership positions must take place for a minimum of one year after the date of first licensure.

e. Practice related programs. Activity will count up to a maximum of eight hours. The board may allow up to eight contact hours of continuing competency as long as the regulant submits proof of attendance plus a written justification of how the activity assists him in his direct service of his clients. Examples include language courses, software training, medical topics, etc.

18 VAC 115-60-117. Documenting compliance with continuing competency requirements.

A. All licensees are required to maintain original documentation for a period of two years following renewal.

B. After the end of each renewal period, the board may conduct a random audit of licensees to verify compliance with the requirement for that renewal period.

C. Upon request, a licensee shall provide documentation as follows:

1. To document completion of formal organized learning activities, licensee shall provide:

- a. Official transcripts showing credit hours earned; or*
- b. Certificates of participation.*

2. Documentation of home study shall be made by identification of the source material studied, summary of content, and a signed affidavit attesting to completion of the home study.

3. Documentation of individual professional activities shall be by one of the following:

- a. Certificates of participation;*
- b. Proof of presentations made;*
- c. Reprints of publications;*
- d. Letters from educational institutions or agencies approving continuing education programs;*
- e. Official notification from the association that sponsored the item writing workshop or continuing education program; or*
- f. Documentation of attendance at formal staffing shall be by signed affidavit on a form provided by the board.*

D. Continuing competency hours required by a disciplinary order shall not be used to satisfy renewal requirements.

18 VAC 115-60-120. Late renewal; reinstatement.

A. A person whose license has expired may renew it within one year after its expiration date by paying the late renewal fee prescribed in 18 VAC 115-60-20, as well as the license fee

prescribed for the year the license was not renewed and providing evidence of having met all applicable continuing competency requirements.

B. A person who fails to renew a license after one year or more and wishes to resume practice shall apply for reinstatement, pay the reinstatement fee for a lapsed license, and submit evidence regarding the continued ability to perform the functions within the scope of practice of the license, and provide evidence of having met all applicable continuing competency requirements not to exceed a maximum of 80 hours.

C. A person wishing to reactivate an inactive license shall submit (i) the renewal fee for active licensure minus any fee already paid for inactive licensure renewal and (ii) documentation of continued competency hours equal to the number of years the license has been inactive not to exceed a maximum of 80 hours.

18 VAC 115-60-140. Grounds for revocation, suspension, probation, reprimand, censure, or denial of renewal of license.

A. Action by the board to revoke, suspend or decline to renew a license may be taken in accord with the following:

- 1. Conviction of a felony, of a misdemeanor involving moral turpitude, or violation of or aid to another in violating any provision of Chapter 35 (§ 54.1-3500 et seq.) of Title 54.1 of the Code of Virginia, any other statute applicable to the practice of substance abuse treatment, or any provision of this chapter.*
- 2. Procuring of license by fraud or misrepresentation.*
- 3. Conducting one's practice in such a manner as to make it a danger to the health and welfare of one's clients or to the public, or if one is unable to practice substance abuse treatment with reasonable skill and safety to clients by reason of illness, abusive use of alcohol, drugs, narcotics, chemicals, or other type of material or result of any mental or physical condition.*
- 4. Negligence in professional conduct or nonconformance with the Standards of Practice (18 VAC 115-60-130).*
- 5. Performance of functions outside the demonstrable areas of competency.*
- 6. Failure to comply with the continued competency requirements set forth in this chapter.*

B. Petition for rehearing. Following the revocation or suspension of a license the licensee may petition the board for rehearing upon good cause shown or as a result of substantial new evidence having been obtained that would alter the determination reached.

VA.R. Doc. Nos. R02-259, R02-260, and R02-258; Filed December 9, 2003, 2:56 p.m.

FINAL REGULATIONS

For information concerning Final Regulations, see Information Page.

Symbol Key

Roman type indicates existing text of regulations. *Italic type* indicates new text. Language which has been stricken indicates text to be deleted. [Bracketed language] indicates a change from the proposed text of the regulation.

TITLE 9. ENVIRONMENT

STATE AIR POLLUTION CONTROL BOARD

Title of Regulation: **9 VAC 5-40. Existing Stationary Sources (amending 9 VAC 5-40-5800, 9 VAC 5-40-5810, 9 VAC 5-40-5820, 9 VAC 5-40-5822, 9 VAC 5-40-5824, 9 VAC 5-40-5850, 9 VAC 5-40-5855, 9 VAC 5-40-5860, 9 VAC 5-40-5870, 9 VAC 5-40-5880, 9 VAC 5-40-5890, 9 VAC 5-40-5910, and 9 VAC 5-40-5920).**

Statutory Authority: § 10.1-1308 of the Code of Virginia; §§ 110, 111, 123, 129, 171, 172, and 182 of the Clean Air Act; 40 CFR Parts 51 and 60.

Effective Date: January 29, 2004.

Agency Contact: Karen G. Sabasteanski, Department of Environmental Quality, P.O. Box 10009, Richmond, VA 23240, telephone (804) 698-4426, FAX (804) 698-4510, or e-mail kgsabastea@deq.state.va.us.

Summary:

The amendments (i) replace general cross references to "design applicability criteria" and "emission rate applicability criteria" with specific criteria throughout the regulation; (ii) revise the specific design capacity criteria for consistency with 40 CFR Part 60; (iii) conform the regulations to comply with the following regulatory revisions promulgated by EPA: June 16, 1998 (63 FR 32743), February 24, 1999 (64 FR 9258), April 10, 2000 (65 FR 18906), October 17, 2000 (65 FR 61778); and (iv) make minor revisions for clarity.

Since publication of the proposed regulation, the following changes were made:

1. In 9 VAC 5-40-5800 C, the requirement to obtain a federal operating permit has been revised to reference 9 VAC 5-80-80 C of the primary operating permit regulation rather than a generic date tied to plan approval or a specific date that is no longer relevant.

2. In 9 VAC 5-40-5810 C, the definitions of "industrial solid waste" and "municipal solid waste landfill" have been revised to better delineate the relationship among the federal law and regulations, and state regulations. Also, the definition of "municipal solid waste landfill" has been revised to reference RCRA regulations in addition to the Virginia regulations.

Summary of Public Comment and Agency Response: A summary of comments made by the public and the agency's response may be obtained from the promulgating agency or viewed at the Office of the Registrar of Regulations.

REGISTRAR'S NOTICE: The proposed regulation was adopted as published in 19:12 VA.R. 1840-1859 February 24, 2003, with the changes identified below. Pursuant to § 2.2-4031 A of the Code of Virginia, the adopted regulation is not published at length; however, the sections that have changed since publication of the proposed are set out.

9 VAC 5-40-5800. Applicability and designation of affected facility.

A. The affected facility to which the provisions of this article apply is each municipal solid waste (MSW) landfill which commenced construction, reconstruction, or modification before May 30, 1991.

B. The provisions of this article apply throughout the Commonwealth of Virginia.

C. For purposes of obtaining a federal operating permit, the owner of an MSW landfill subject to this article with a design capacity less than 2.5 million megagrams or 2.5 million cubic meters is not subject to the requirement to obtain a federal operating permit for the landfill, unless the landfill is otherwise subject to federal operating permit requirements. For purposes of submitting a timely application for a federal operating permit, the owner of an MSW landfill subject to this article with a design capacity greater than or equal to 2.5 million megagrams and 2.5 million cubic meters on the effective date of EPA approval of the board's program under § 111(d) of the federal Clean Air Act, and otherwise not subject to federal operating permit requirements, [~~becomes subject to federal operating permit requirements 90 days after the effective date of such § 111(d) program approval shall submit an operating permit application as provided in 9 VAC 5-80-80 C~~], even if the design capacity report is submitted earlier.

D. When an MSW landfill subject to this article becomes closed, the owner is no longer subject to the requirement to maintain a federal operating permit for the landfill if the landfill is not otherwise subject to federal operating permit requirements and if either of the following conditions is met:

1. The landfill was never subject to the requirement for a control system under 9 VAC 5-40-5820 C 2; or
2. The owner meets the conditions for control system removal specified in 9 VAC 5-40-5820 C 2 e.

E. Activities required by or conducted pursuant to a CERCLA, RCRA, or board remedial action are not considered construction, reconstruction, or modification for the purposes of this article.

9 VAC 5-40-5810. Definitions.

A. For the purpose of *applying this article in the context of the Regulations for the Control and Abatement of Air Pollution and subsequent amendments or any orders issued by the board*

related uses, the words or terms shall have the meanings given them in subsection C of this section.

B. As used in this article, all terms not defined here shall have the meanings given them in 9 VAC 5 Chapter 10 (9 VAC 5-10-10 ~~et seq.~~), unless otherwise required by context.

C. Terms defined.

"*Active collection system*" means a gas collection system that uses gas mover equipment.

"*Active landfill*" means a landfill in which solid waste is being placed or a landfill that is planned to accept waste in the future.

"*CERCLA*" means the federal Comprehensive Environmental Response, Compensation and Liability Act (42 USC § 9601 et seq.).

"*Closed landfill*" means a landfill in which solid waste is no longer being placed, and in which no additional solid wastes will be placed without first ~~obtaining a permit or permit amendment under Part VII (9 VAC 20-80-480 et seq.) of 9 VAC 20 Chapter 80 (Solid Waste Management Regulations) filing a notification of modification, as prescribed under 40 CFR 60.7(a)(4), with the board. Once such permit a notification of modification has been issued filed,~~ and additional solid waste is placed in the landfill, the landfill is no longer closed.

"*Closure*" means that point in time when a landfill becomes a closed landfill.

"*Commenced*" means that an owner has undertaken a continuous program of construction or modification or that an owner has entered into a contractual obligation to undertake and complete, within a reasonable time, a continuous program of construction or modification.

"*Commercial waste*" means all types of solid waste generated by stores, offices, restaurants, warehouses, and other nonmanufacturing activities, excluding construction, household, and industrial wastes.

"*Construction*" means fabrication, erection, or installation of an affected facility.

"*Controlled landfill*" means any landfill at which collection and control systems are required under this article as a result of the nonmethane organic compounds emission rate. The landfill is considered controlled at the time a collection and control system design plan is submitted in compliance with 9 VAC 5-40-5820 C 2 a.

"*Design capacity*" means the maximum amount of solid waste a landfill can accept, as indicated in terms of volume or mass in the most recent permit issued *by the department* under Part VII (9 VAC 20-80-480 et seq.) of 9 VAC 20 Chapter 80 (Solid Waste Management Regulations), plus any in-place waste not accounted for in the most recent permit, or as calculated using good engineering practices acceptable to the board. If the owner chooses to convert the design capacity from volume to mass or from mass to volume to demonstrate that its design capacity is less than ~~the design capacity applicability criteria in 9 VAC 5-40-5820-A~~ (i) 1.0 million megagrams or 1.0 million cubic meters in the Northern Virginia Volatile Organic Compound Emissions Control Area or (ii) 2.5 million megagrams or 2.5

million cubic meters in the remaining areas of the Commonwealth, the calculation must include a site-specific density, which must be recalculated annually.

"*Disposal facility*" means all contiguous land and structures, other appurtenances, and improvements on the land used for the disposal of solid waste.

"*Emission rate cutoff*" means the threshold annual emission rate to which a landfill compares its estimated emission rate to determine if control under the regulation is required.

"*Enclosed combustor*" means an enclosed firebox which maintains a relatively constant limited peak temperature generally using a limited supply of combustion air. An enclosed flare is considered an enclosed combustor.

"*Federal operating permit*" means a permit issued under Article 1 (9 VAC 5-80-50 et seq.) ~~or Article 3 (9 VAC 5-80-360 et seq.)~~ of Part II of 9 VAC 5 Chapter 80.

"*Flare*" means an open combustor without enclosure or shroud.

~~"*Gas management system*" means a method for the collection and destruction or use of landfill gases.~~

"*Gas mover equipment*" means the equipment (i.e., fan, blower, compressor) used to transport landfill gas through the header system.

"*Household waste*" mean any solid waste, including garbage, trash and refuse, derived from households (including, but not limited to, single and multiple residences, hotels and motels, bunkhouses, ranger stations, crew quarters, campgrounds, picnic grounds and day-use recreational areas). For the ~~purpose~~ purposes of determining capacity as required by 9 VAC 5-40-5820 and NMOC emission rates as required by 9 VAC 5-40-5860, household ~~wastes include~~ waste includes sanitary waste (septage) in septic tanks.

"*Industrial solid waste*" means any solid waste generated by manufacturing or industrial processes that is not a hazardous waste regulated under Subtitle C [(42 USC § 6921 et seq.)] of RCRA [(as reflected in] 40 CFR Parts 264 and 265) [;] and [implemented by the department in] 9 VAC 20 Chapter 60 (9 VAC 20-60-12 ~~et seq.~~, Virginia Hazardous Waste Management Regulations). Such waste may include, but is not limited to, waste resulting from the following manufacturing processes: electric power generation; fertilizer and agricultural chemicals; food and related products and byproducts; inorganic chemicals; iron and steel manufacturing; leather and leather products; nonferrous metals manufacturing and foundries; organic chemicals; plastics and resins manufacturing; pulp and paper industry; rubber and miscellaneous plastic products; stone, glass, clay, and concrete products; textile manufacturing; transportation equipment; and water treatment. This term does not include mining waste or oil and gas waste.

"*Interior well*" means any well or similar collection component located inside the perimeter of the landfill waste. A perimeter well located outside the landfilled waste is not an interior well.

"*Landfill*" means an area of land or an excavation in which wastes are placed for permanent disposal, and that is not a

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land application unit, surface impoundment, injection well, or waste pile as those terms are defined under ~~Part I (9 VAC 20-80-10 et seq.) of 9 VAC 20 Chapter 80 (Solid Waste Management Regulations).~~

"*Landfill gas*" means any gas derived from the decomposition of organic waste deposited in an MSW landfill or from the evolution of volatile organic species in the waste. Emissions from MSW landfills is equivalent to landfill gas emissions.

"*Lateral expansion*" means a horizontal expansion of the waste boundaries of an existing MSW landfill. A lateral expansion is not a modification unless it results in an increase in the design capacity of the landfill.

"*Modification*" means an increase in the permitted volume design capacity of the landfill by either horizontal or vertical expansion based on its permitted design capacity as of May 30, 1991. *Modification does not occur until the owner commences construction on the horizontal or vertical expansion.*

"*Municipal solid waste landfill*" or "*MSW landfill*" means an entire disposal facility in a contiguous geographical space where household waste is placed in or on land. An MSW landfill may also receive other types of solid wastes [*regulated under Subtitle D (42 USC § 6941 et seq.) of RCRA (as reflected in 40 CFR 257.2) and implemented by the department in 9 VAC 20-80-250 (Solid Waste Management Regulations)*] such as commercial solid waste, nonhazardous sludge, conditionally exempt small quantity generator waste, and nonhazardous industrial solid waste [~~as provided in 9 VAC 20-80-250 (Solid Waste Management Regulations)~~]. Portions of an MSW landfill may be separated by access roads. An MSW landfill may be publicly or privately owned. An MSW landfill may be a new MSW landfill, an existing MSW landfill, or a lateral expansion.

"*Municipal solid waste landfill emissions*" or "*MSW landfill emissions*" means gas generated by the decomposition of organic waste deposited in an MSW landfill or derived from the evolution of organic compounds in the waste.

"*NMOC*" means nonmethane organic compounds, as measured according to the provisions of 9 VAC 5-40-5860 B through E.

"*Nondegradable waste*" means any waste that does not decompose through chemical breakdown or microbiological activity. Examples include, but are not limited to, concrete, municipal waste combustor ash, and metals.

"*Passive collection system*" means a gas collection system that solely uses positive pressure within the landfill to move the gas rather than using gas mover equipment.

~~"*Offsite gas migration*" means underground landfill gases detected at any point on the landfill perimeter.~~

"*RCRA*" means the federal Resource Conservation and Recovery Act (42 USC § 6901 et seq.).

"*Refuse*" means trash, rubbish, garbage, and other forms of solid or liquid waste, including, but not limited to, wastes resulting from residential, agricultural, commercial, industrial, institutional, trade, construction, land clearing, forest management, and emergency operations.

"*Sludge*" means any solid, semi-solid, or liquid waste generated from a municipal, commercial, or industrial wastewater treatment plant, water supply treatment plant, or air pollution control facility exclusive of the treated effluent from a wastewater treatment plant.

"*Solid waste*" means any garbage, sludge from a wastewater treatment plant, water supply treatment plant, or air pollution control facility and other discarded material, including solid, liquid, semi-solid, or contained gaseous material resulting from industrial, commercial, mining, and agricultural operations, and from community activities, but does not include solid or dissolved material in domestic sewage, or solid or dissolved materials in irrigation return flows or industrial discharges that are point sources subject to permits under 33 USC § 1342, or source, special nuclear, or byproduct material as defined by the Atomic Energy Act of 1954 (42 USC § 2011 et seq.). For more detail, see Part III (9 VAC 20-80-130 et seq.) of 9 VAC 20 Chapter 80 (Solid Waste Management Regulations).

"*Sufficient density*" means any number, spacing, and combination of collection system components, including vertical wells, horizontal collectors, and surface collectors, necessary to maintain emission and migration control as determined by measures of performance set forth in this part.

"*Sufficient extraction rate*" means a rate sufficient to maintain a negative pressure at all wellheads in the collection system without causing air infiltration, including any wellheads connected to the system as a result of expansion or excess surface emissions, for the life of the blower.

9 VAC 5-40-5820. [No change from proposed].

9 VAC 5-40-5822. Operational standards for collection and control systems.

A. Each owner of an MSW landfill with a gas collection and control system used to comply with the provisions of 9 VAC 5-40-5820 C 2 b shall *comply with the following requirements*:

~~A-~~ 1. Operate the collection system such that gas is collected from each area, cell, or group of cells in the MSW landfill in which solid waste has been in place for:

- ~~1-~~ a. Five years or more if active; or
- ~~2-~~ b. Two years or more if closed or at final grade;

B- 2. Operate the collection system with negative pressure at each wellhead except under the following conditions:

- ~~1-~~ a. A fire or increased well temperature. The owner shall record instances when positive pressure occurs in efforts to avoid a fire. These records shall be submitted with the annual reports as provided in 9 VAC 5-40-5880 H 1;
- ~~2-~~ b. Use of a geomembrane or synthetic cover. The owner shall develop acceptable pressure limits in the design plan; *and*
- ~~3-~~ c. A decommissioned well. A well may experience a static positive pressure after shut down to accommodate for declining flows. All design changes shall be approved by the board;

~~C~~. 3. Operate each interior wellhead in the collection system with a landfill gas temperature less than 55 [~~C~~ *degrees Celsius*] and with either a nitrogen level less than 20% or an oxygen level less than 5.0%. The owner may establish a higher operating temperature, nitrogen, or oxygen value at a particular well. A higher operating value demonstration shall show supporting data that the elevated parameter does not cause fires or significantly inhibit anaerobic decomposition by killing methanogens.

~~4~~. a. The nitrogen level shall be determined using Reference Method 3C in Appendix A of 40 CFR Part 60, unless an alternative method is established as allowed by 9 VAC 5-40-5820 C 2 a.

~~2~~. b. Unless an alternative method is established as allowed by 9 VAC 5-40-5820 C 2 a, the oxygen shall be determined by an oxygen meter using Reference Method 3A in Appendix A of 40 CFR Part 60 except that:

- ~~a~~. (1) The span shall be set so that the regulatory limit is between 20 and 50% of the span;
- ~~b~~. (2) A data recorder is not required;
- ~~c~~. (3) Only two calibration gases are required, a zero and span, and ambient air may be used as the span;
- ~~d~~. (4) A calibration error check is not required; *and*
- ~~e~~. (5) The allowable sample bias, zero drift, and calibration drift are $\pm 10\%$.

~~D~~. 4. Operate the collection system so that the methane concentration is less than 500 parts per million above background at the surface of the landfill. To determine if this level is exceeded, the owner shall conduct surface testing around the perimeter of the collection area and along a pattern that traverses the landfill at 30-meter intervals and where visual observations indicate elevated concentrations of landfill gas, such as distressed vegetation and cracks or seeps in the cover. The owner may establish an alternative traversing pattern that ensures equivalent coverage. A surface monitoring design plan shall be developed that includes a topographical map with the monitoring route and the rationale for any site-specific deviations from the 30-meter intervals. Areas with steep slopes or other dangerous areas may be excluded from the surface testing.

~~E~~. 5. Operate the system such that all collected gases are vented to a control system designed and operated in compliance with 9 VAC 5-40-5820 C 2 c. In the event the collection or control system is inoperable, the gas mover system shall be shut down and all valves in the collection and control system contributing to venting of the gas to the atmosphere shall be closed within one hour; ~~and~~.

~~F~~. 6. Operate the control or treatment system at all times when the collected gas is routed to the system.

~~G~~. B. If monitoring demonstrates that the operational requirement in ~~subsections B, C, or D subdivision A 2, 3 or 4~~ of this section are not met, corrective action shall be taken as specified in 9 VAC 5-40-5850 C 3 through 5 or 9 VAC 5-40-5850 E. If corrective actions are taken as specified in

9 VAC 5-40-5850, the monitored exceedance is not a violation of the operational requirements in this section.

9 VAC 5-40-5824 through 9 VAC 5-40-5860 [No change from proposed].

9 VAC 5-40-5870. Monitoring.

A. The provisions of 9 VAC 5-40-40 (Monitoring) apply.
 B. Except as provided in 9 VAC 5-40-5820 C 2 a (2), the provisions of subsections C through H of this section apply.

C. Each owner seeking to comply with 9 VAC 5-40-5820 C 2 b (1) for an active gas collection system shall install a sampling port and a thermometer, other temperature measuring device, or an access port for temperature measurements at each wellhead and:

- 1. Measure the gauge pressure in the gas collection header on a monthly basis as provided in 9 VAC 5-40-5850 C 3; and
- 2. Monitor nitrogen or oxygen concentration in the landfill gas on a monthly basis as provided in 9 VAC 5-40-5850 C 5; and
- 3. Monitor temperature of the landfill gas on a monthly basis as provided in 9 VAC 5-40-5850 C 5.

D. Each owner seeking to comply with 9 VAC 5-40-5820 C 2 c using an enclosed combustor shall calibrate, maintain, and operate according to the manufacturer's specifications, the following equipment:

- 1. A temperature monitoring device equipped with a continuous recorder and having a minimum accuracy of ± 1.0 percent of the temperature being measured expressed in degrees Celsius or ± 0.5 [~~C~~ *degrees Celsius*], whichever is greater. A temperature monitoring device is not required for boilers or process heaters with design heat input capacity *equal to or* greater than 44 megawatts.
- 2. A device that records flow to or bypass of the control device. The owner shall either:
 - a. Install, calibrate, and maintain a gas flow rate measuring device that shall record the flow to the control device at least every 15 minutes; or
 - b. Secure the bypass line valve in the closed position with a car-seal or a lock-and-key type configuration. A visual inspection of the seal or closure mechanism shall be performed at least once every month to ensure that the valve is maintained in the closed position and that the gas flow is not diverted through the bypass line.

E. Each owner seeking to comply with 9 VAC 5-40-5820 C 2 c using an open flare shall install, calibrate, maintain, and operate according to the manufacturer's specifications the following equipment:

- 1. A heat sensing device, such as an ultraviolet beam sensor or thermocouple, at the pilot light or the flame itself to indicate the continuous presence of a flame.
- 2. A device that records flow to or bypass of the flare. The owner shall either:

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a. Install, calibrate, and maintain a gas flow rate measuring device that shall record the flow to the control device at least every 15 minutes; or

b. Secure the bypass line valve in the closed position with a car-seal or a lock-and-key type configuration. A visual inspection of the seal or closure mechanism shall be performed at least once every month to ensure that the valve is maintained in the closed position and that the gas flow is not diverted through the bypass line.

F. Each owner seeking to demonstrate compliance with 9 VAC 5-40-5820 C 2 c using a device other than an open flare or an enclosed combustor shall provide information acceptable to the board as provided in 9 VAC 5-40-5820 C 2 a (2) describing the operation of the control device, the operating parameters that would indicate proper performance, and appropriate monitoring procedures. The board ~~shall~~ will review the information and either approve it, or request that additional information be submitted. The board may specify additional appropriate monitoring procedures.

G. Each owner seeking to install a collection system that does not meet the specifications in 9 VAC 5-40-5824 or seeking to monitor alternative parameters to those required by 9 VAC 5-40-5822, 9 VAC 5-40-5850, 9 VAC 5-40-5860, and 9 VAC 5-40-5870 shall provide information acceptable to the board as provided in 9 VAC 5-40-5820 C 2 a (2) and (3) describing the design and operation of the collection system, the operating parameters that would indicate proper performance, and appropriate monitoring procedures. The board may specify additional appropriate monitoring procedures.

H. Each owner seeking to demonstrate compliance with 9 VAC 5-40-5850 E, shall monitor surface concentrations of methane according to the instrument specifications and procedures provided in 9 VAC 5-40-5850 F. Any closed landfill that has no monitored exceedances of the operational standard in three consecutive quarterly monitoring periods may skip to annual monitoring. Any methane reading of 500 parts per million or more above background detected during the annual monitoring returns the frequency for that landfill to quarterly monitoring.

9 VAC 5-40-5880. [No change from proposed].

9 VAC 5-40-5890. Recordkeeping.

A. The provisions of 9 VAC 5-40-50 (Notification, records and reporting) apply.

B. Except as provided in 9 VAC 5-40-5820 C 2 a (2), the provisions of subsections C through G of this section apply.

C. Each owner of an MSW landfill subject to the provisions of 9 VAC 5-40-5820 C shall keep for at least five years up-to-date, readily accessible, on-site records of the design capacity report which triggered 9 VAC 5-40-5820 C, the current amount of solid waste in-place, and the year-by-year waste acceptance rate. Off-site records may be maintained if they are retrievable within four hours. Either paper copy or electronic formats are acceptable.

D. Each owner of a controlled landfill shall keep up-to-date, readily accessible records for the life of the control equipment of the data listed in subdivisions D 1 through D 4 of this

section as measured during the initial compliance test or compliance determination. Records of subsequent tests or monitoring shall be maintained for a minimum of five years. Records of the control device vendor specifications shall be maintained until removal.

1. Where an owner subject to the provisions of this article seeks to demonstrate compliance with 9 VAC 5-40-5820 C 2 b:

a. The maximum expected gas generation flow rate as calculated in 9 VAC 5-40-5850 C 1. The owner may use an alternative method to determine the maximum gas generation flow rate, if the method has been approved by the board.

b. The density of wells, horizontal collectors, surface collectors, or other gas extraction devices determined using the procedures specified in 9 VAC 5-40-5824 A 1.

2. Where an owner subject to the provisions of this article seeks to demonstrate compliance with 9 VAC 5-40-5820 C 2 c through use of an enclosed combustion device other than a boiler or process heater with a design heat input capacity *equal to or greater than* 44 megawatts:

a. The average combustion temperature measured at least every 15 minutes and averaged over the same time period of the compliance test.

b. The percent reduction of NMOC determined as specified in 9 VAC 5-40-5820 C 2 c (2) achieved by the control device.

3. Where an owner subject to the provisions of this article seeks to demonstrate compliance with 9 VAC 5-40-5820 C 2 c (2) (a) through use of a boiler or process heater of any size: a description of the location at which the collected gas vent stream is introduced into the boiler or process heater over the same time period of the compliance testing.

4. Where an owner subject to the provisions of this article seeks to demonstrate compliance with 9 VAC 5-40-5820 C 2 c (1) through use of an open flare, the flare type (i.e., steam-assisted, air-assisted, or nonassisted), all visible emission readings, heat content determination, flow rate or bypass flow rate measurements, and exit velocity determinations made during the compliance test as *specified in 40 CFR 60.18*; continuous records of the flare pilot flame or flare flame monitoring and records of all periods of operations during which the pilot flame of the flare flame is absent.

E. Each owner of a controlled landfill subject to the provisions of this article shall keep for five years up-to-date, readily accessible continuous records of the equipment operating parameters specified to be monitored in 9 VAC 5-40-5870 as well as up-to-date, readily accessible records for periods of operation during which the parameter boundaries established during the most recent compliance test are exceeded.

1. The following constitute exceedances that shall be recorded and reported under 9 VAC 5-40-5880 H:

a. For enclosed combustors except for boilers and process heaters with design heat input capacity of 44

megawatts (150 million British thermal units per hour) or greater, all three-hour periods of operation during which the average combustion temperature was more than 28 [°C degrees Celsius] below the average combustion temperature during the most recent compliance test at which compliance with 9 VAC 5-40-5820 C 2 c was determined.

b. For boilers or process heaters, whenever there is a change in the location at which the vent stream is introduced into the flame zone as required under subdivision D 3 a of this section.

2. Each owner subject to the provisions of this article shall keep up-to-date, readily accessible continuous records of the indication of flow to the control device or the indication of bypass flow or records of monthly inspections of car-seals or lock-and-key configurations used to seal bypass lines, specified under 9 VAC 5-40-5870.

3. Each owner subject to the provisions of this article who uses a boiler or process heater with a design heat input capacity of 44 megawatts or greater to comply with 9 VAC 5-40-5820 C 2 c shall keep an up-to-date, readily accessible record of all periods of operation of the boiler or process heater. (Examples of such records could include records of steam use, fuel use, or monitoring data collected pursuant to other state or federal regulatory requirements.)

4. Each owner seeking to comply with the provisions of this article by use of an open flare shall keep up-to-date, readily accessible continuous records of the flame or flare pilot flame monitoring specified under 9 VAC 5-40-5870 E, and up-to-date, readily accessible records of all periods of operation in which the flame or flare pilot flame is absent.

F. Each owner subject to the provisions of this article shall keep for the life of the collection system an up-to-date, readily accessible plot map showing each existing and planned collector in the system and providing a unique identification location label for each collector.

1. Each owner subject to the provisions of this article shall keep up-to-date, readily accessible records of the installation date and location of all newly installed collectors as specified under 9 VAC 5-40-5850 D.

2. Each owner subject to the provisions of this article shall keep readily accessible documentation of the nature, date of deposition, amount, and location of asbestos-containing or nondegradable waste excluded from collection as provided in 9 VAC 5-40-5824 A 3 a as well as any nonproductive areas excluded from collection as provided in 9 VAC 5-40-5824 A 3 b.

G. Each owner subject to the provisions of this article shall keep for at least five years up-to-date, readily accessible records of all collection and control system exceedances of the operational standards in 9 VAC 5-40-5822, the reading in the subsequent month whether or not the second reading is an exceedance, and the location of each exceedance.

H. Landfill owners who convert design capacity from volume to mass or from mass to volume to demonstrate that the landfill design capacity is less than the design capacity applicability criteria in 9 VAC 5-40-5820 A (i) 1.0 million

megagrams or 1.0 million cubic meters in the Northern Virginia Volatile Organic Compound Emissions Control Area or (ii) 2.5 million megagrams or 2.5 million cubic meters in the remaining areas of the Commonwealth, as provided in the definition of "design capacity," shall keep readily accessible, on-site records of the annual recalculation of site-specific density, design capacity, and the supporting documentation. Off-site records may be obtained if they are retrievable within four hours. Either paper copy or electronic formats are acceptable.

9 VAC 5-40-5910 and 9 VAC 5-40-5920. [No change from proposed.]

VA.R. Doc. No. R02-294; Filed December 9, 2003, 1:44 p.m.

TITLE 12. HEALTH

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Titles of Regulations: **12 VAC 30-70. Methods and Standards for Establishing Payment Rates; Inpatient Hospital Care (adding 12 VAC 30-70-425 and 12 VAC 30-70-426).**

12 VAC 30-80. Methods and Standards for Establishing Payment Rates; Other Types of Care (amending 12 VAC 30-80-20 and 12 VAC 30-80-30).

~~**[12 VAC 30-90. Methods and Standards for Establishing Payment Rates for Long Term Care (adding 12 VAC 30-90-17 and 12 VAC 30-90-18)].**~~

Statutory Authority: §§ 32.1-324 and 32.1-325 of the Code of Virginia and Items 325CC, 325DD, and 325RR of Chapter 899 of the 2002 Acts of Assembly.

Effective Date: January 28, 2004.

Agency Contact: William Lessard, Reimbursement Analyst, Reimbursement and Cost Settlement, Department of Medical Assistance Services, 600 E. Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 225-4593, FAX (804) 786-1680, or e-mail wlessard.dmas.state.va.us.

Summary:

The regulations authorize the Department of Medical Assistance Services to increase reimbursement for government-owned public nursing homes, hospitals, and clinics consistent with the maximum reimbursement allowed under federal laws and regulations. DMAS made substantial changes to the previous proposed regulations in order to be authorized by the Centers for Medicare and Medicaid to receive federal financial participation for these supplemental payments.

The final regulations clarify which institutions are eligible to receive supplemental payments, add a methodology for determining the total amount of payments available, and revise the methodology for determining the amount of payment each provider is eligible to receive. The final regulation also deletes proposed regulations that provided

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for supplemental payments to state owned/operated nursing facilities and Intermediate Care Facilities for the Mentally Retarded.

Summary of Public Comment and Agency Response: No public comments were received by the promulgating agency.

12 VAC 30-70-425. Supplemental payments to nonstate government-owned hospitals for inpatient services.

~~[A. In addition to payments for inpatient hospital services provided for elsewhere in this State Plan, DMAS makes supplemental payments to nonstate government owned or operated hospitals for services provided to Medicaid patients on or after July 1, 2002. To qualify for a supplemental payment, the hospital must be owned or operated by a unit of government or public entity other than the state.~~

~~B. The amount of the supplemental payment made to each nonstate government owned or operated hospital is determined by:~~

~~1. Calculating for each hospital the annual difference between the lower of the limit specified in 42 CFR 447.271 or the limit specified at 42 USC § 1396r-4(g) and the amount otherwise actually paid for the services by the Medicaid program;~~

~~2. Dividing the difference determined in subdivision 1 of this subsection for the hospital by the aggregate difference for all such hospitals; and~~

~~3. Multiplying the proportion determined in subdivision 2 of this subsection by the aggregate upper payment limit amount for all such hospitals as determined in accordance with 42 CFR 447.272 less all payments made to such hospitals other than under this section.~~

~~C. Payments made under this section may be made in one or more installments at such times, within the fiscal year or thereafter, as is determined by DMAS.~~

A. DMAS shall provide lump sum supplemental payments to participating nonstate government-owned hospitals for furnished inpatient services provided to Medicaid patients on or after December 16, 2001. The supplemental payments are made from a pool of funds, the amount of which is the difference between the Medicaid payments otherwise made to all nonstate government-owned hospitals for services to Medicaid patients and the maximum amount allowable under applicable federal regulations in accordance with 42 CFR 447.272. A participating hospital is one with respect to which a transfer agreement has been made and implemented.

B. A nonstate government-owned hospital is owned or operated by a unit of government other than a state. The payment amount for a participating hospital is the hospital's proportionate share of the established pool of funds determined by dividing the hospital's Medicaid days provided during the most recent fiscal year by the total Medicaid days provided by all participating nonstate government-owned hospitals for the same fiscal year.

C. A payment made to a hospital under this provision when combined with other payments made under the State Plan shall not exceed the limit specified in 42 CFR 447.271 or the

limit specified in 42 USC § 1396r-4(g). Any amount not included in a payment because of the operation of the preceding sentence shall be distributed to other participating hospitals in the same manner and subject to the same limitations as set forth above.

D. For the period from December 16, 2001, through May 13, 2002, aggregate payments to nonstate government-owned hospitals shall not exceed 150% of a reasonable estimate of the amount that would be paid for the services furnished by these hospitals under Medicare payment principles. For the period beginning May 14, 2002, aggregate payments to these hospitals shall not exceed 100% of a reasonable estimate of the amount that would be paid for the services furnished by these hospitals under Medicare payment principles.

E. To determine the reasonable estimate of the amount that would be payable under Medicare payment principles, a hospital-specific per diem will be determined by dividing all inpatient hospital costs for acute, psychiatric and rehabilitation services by the total number of patient days. The hospital-specific per diem will be multiplied by the hospital's Medicaid bed days. The reasonable estimate will be the sum of the calculations for all hospitals. The calculation will use data from the last settled cost report for all nonstate government-owned hospitals at the beginning of the state fiscal year for which calculations are made. However, for state fiscal year 2002, only data from the last settled cost report at the beginning of state fiscal year 2003 will be used. Charges and Medicaid payments will be trended forward using the Virginia-specific DRI-hospital inflation factors. Medicare payments will be trended forward using CMS Medicare inflators. Additional adjustments will be made for any statutory changes in Medicare or Medicaid payments. The most recently available Medicaid DSH data will be used.]

12 VAC 30-70-426. Supplemental payments to state government-owned hospitals for inpatient services.

A. In addition to payments for inpatient hospital services provided for elsewhere in this State Plan, DMAS makes supplemental payments to state government-owned or operated hospitals for services provided to Medicaid patients on or after July 2, 2002. To qualify for a supplemental payment, the hospital must be [~~owned or operated by the state~~ part of a state academic health system or part of an academic health system that operates under a state authority].

B. The amount of the supplemental payment made to each [qualifying] state government-owned or operated hospital is determined by:

1. Calculating for each hospital the annual difference between the [~~lower of the limit specified in 42 CFR 447.271 or the limit specified at 42 USC § 1396r-4(g)~~ upper payment limit attributed to each qualifying hospital calculated according to subsection D of this section] and the amount otherwise actually paid for the services by the Medicaid program;

2. Dividing the difference determined in subdivision 1 of this subsection for [~~the each~~ qualifying] hospital by the [~~total~~ aggregate] difference for all such [qualifying] hospitals; and

3. Multiplying the proportion determined in subdivision 2 of this subsection by the aggregate upper payment limit amount for all such hospitals as determined in accordance with 42 CFR 447.272 less all payments made to such hospitals other than under this section.

C. Payments under this section may be made in one or more installments at such time, within the fiscal year or thereafter, as is determined by DMAS.

[D. To determine the aggregate upper payment limit amount as referred to in subdivision B 3 of this section, the following methodology will be used. For cost-reimbursed hospitals, the upper payment limit is costs. By definition, cost-reimbursed hospitals have no net impact on the upper payment limit and will be excluded from the calculation. For Medicaid DRG-reimbursed hospitals, a ratio will be calculated for each hospital by dividing its Medicare payments by Medicare charges. This Medicare payment-to-charge ratio will be multiplied by Medicaid charges for each DRG-reimbursed hospital. The upper payment limit will be the sum of the product of that multiplication for all DRG-reimbursed hospitals. The calculation will use data from the last settled cost report for all state government-owned hospitals at the beginning of the state fiscal year for which calculations are made. Charges will be trended forward using hospital-specific data if available. If not available, charges will be trended forward using the Virginia-specific DRI hospital inflation factors. Additional adjustments will be made for any program changes in Medicare or Medicaid payments. The most recently available data on Medicaid DSH payments will be used.]

12 VAC 30-80-20. Services [which that] are reimbursed on a cost basis.

A. Payments for services listed below shall be on the basis of reasonable cost following the standards and principles applicable to the Title XVIII Program. The upper limit for reimbursement shall be no higher than payments for Medicare patients on a facility by facility basis in accordance with 42 CFR 447.321 and 42 CFR 447.325. In no instance, however, shall charges for beneficiaries of the program be in excess of charges for private patients receiving services from the provider. The professional component for emergency room physicians shall continue to be uncovered as a component of the payment to the facility.

B. Reasonable costs will be determined from the filing of a uniform cost report by participating providers. The cost reports are due not later than 90 days after the provider's fiscal year end. If a complete cost report is not received within 90 days after the end of the provider's fiscal year, the Program shall take action in accordance with its policies to assure that an overpayment is not being made. The cost report will be judged complete when DMAS has all of the following:

1. Completed cost reporting form(s) provided by DMAS, with signed certification(s);
2. The provider's trial balance showing adjusting journal entries;
3. The provider's financial statements including, but not limited to, a balance sheet, a statement of income and

expenses, a statement of retained earnings (or fund balance), and a statement of changes in financial position;

4. Schedules [~~which that~~] reconcile financial statements and trial balance to expenses claimed in the cost report;

5. Depreciation schedule or summary;

6. Home office cost report, if applicable; and

7. Such other analytical information or supporting documents requested by DMAS when the cost reporting forms are sent to the provider.

C. Item 398 D of the 1987 Appropriation Act (as amended), effective April 8, 1987, eliminated reimbursement of return on equity capital to proprietary providers.

D. The services that are cost reimbursed are:

1. Inpatient hospital services to persons over 65 years of age in tuberculosis and mental disease hospitals.

2. Outpatient hospital services excluding laboratory.

a. Definitions. The following words and terms, when used in this regulation, shall have the following meanings when applied to emergency services unless the context clearly indicates otherwise:

"All-inclusive" means all emergency department and ancillary service charges claimed in association with the emergency room visit, with the exception of laboratory services.

"DMAS" means the Department of Medical Assistance Services consistent with Chapter 10 (§ 32.1-323 et seq.) of Title 32.1 of the Code of Virginia.

"Emergency hospital services" means services that are necessary to prevent the death or serious impairment of the health of the recipient. The threat to the life or health of the recipient necessitates the use of the most accessible hospital available that is equipped to furnish the services.

"Recent injury" means an injury ~~which that~~ occurred less than 72 hours prior to the emergency department visit.

b. Scope. DMAS shall differentiate, as determined by the attending physician's diagnosis, the kinds of care routinely rendered in emergency departments and reimburse for nonemergency care rendered in emergency departments at a reduced rate.

(1) With the exception of laboratory services, DMAS shall reimburse at a reduced and all-inclusive reimbursement rate for all services, including those obstetric and pediatric procedures contained in 12 VAC 30-80-160, rendered in emergency departments [~~which that~~] DMAS determines were nonemergency care.

(2) Services determined by the attending physician to be emergencies shall be reimbursed under the existing methodologies and at the existing rates.

(3) Services performed by the attending physician [~~which that~~] may be emergencies shall be manually

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reviewed. If such services meet certain criteria, they shall be paid under the methodology for subdivision 2 b (2) of this subsection. Services not meeting certain criteria shall be paid under the methodology of subdivision 2b (1) of this subsection. Such criteria shall include, but not be limited to:

(a) The initial treatment following a recent obvious injury.

(b) Treatment related to an injury sustained more than 72 hours prior to the visit with the deterioration of the symptoms to the point of requiring medical treatment for stabilization.

(c) The initial treatment for medical emergencies including indications of severe chest pain, dyspnea, gastrointestinal hemorrhage, spontaneous abortion, loss of consciousness, status epilepticus, or other conditions considered life threatening.

(d) A visit in which the recipient's condition requires immediate hospital admission or the transfer to another facility for further treatment or a visit in which the recipient dies.

(e) Services provided for acute vital sign changes as specified in the provider manual.

(f) Services provided for severe pain when combined with one or more of the other guidelines.

(4) Payment shall be determined based on ICD-9-CM diagnosis codes and necessary supporting documentation.

(5) DMAS shall review on an ongoing basis the effectiveness of this program in achieving its objectives and for its effect on recipients, physicians, and hospitals. Program components may be revised subject to achieving program intent, the accuracy and effectiveness of the ICD-9-CM code designations, and the impact on recipients and providers.

3. Rehabilitation agencies. Reimbursement for physical therapy, occupational therapy, and speech-language therapy services shall not be provided for any sums that the rehabilitation provider collects, or is entitled to collect, from the NF or any other available source, and provided further, that this amendment shall in no way diminish any obligation of the NF to DMAS to provide its residents such services, as set forth in any applicable provider agreement.

4. Comprehensive outpatient rehabilitation facilities.

5. Rehabilitation hospital outpatient services.

6. *Supplemental payments to nonstate government-owned hospitals for outpatient services.*

~~[a. In addition to payments for services set forth elsewhere in this State Plan, DMAS provides supplemental payments to nonstate government owned or operated hospitals for outpatient services provided to Medicaid patients on or after July 1, 2002. To qualify for a supplemental payment, the hospital must be owned or operated by a unit of government other than the state.~~

~~b. The amount of the supplemental payment made to each nonstate government-owned or operated hospital is determined by:~~

~~(1) Calculating the difference between the lower of the limit specified in 42 CFR 447.325 or the limit specified at 42 USC § 1396r-4 (g) and the amount otherwise actually paid for the services by the Medicaid program;~~

~~(2) Dividing the difference determined in subdivision (1) of this subdivision 6 b by the aggregate upper payment limit amount for all such hospitals; and~~

~~(3) Multiplying the proportion determined in subdivision (2) of this subdivision 6 b by the aggregate upper payment limit amount for all such hospitals as determined in accordance with 42 CFR 447.321 less all payments made to such hospitals other than under this section.~~

~~c. Payments made under this section may be made in one or more installments at such times, within the fiscal year or thereafter, as is determined by DMAS.~~

~~a. The department provides lump sum supplemental payments to participating nonstate government-owned hospitals for furnished outpatient services provided to Medicaid patients on or after December 16, 2001. The supplemental payments are made from a pool of funds, the amount of which is the difference between the Medicaid payments otherwise made to all nonstate government-owned hospitals for outpatient services to Medicaid patients and the maximum amount allowable under applicable federal regulations at 42 CFR 447.321. A participating hospital is one with respect to which a transfer agreement has been made and implemented.~~

~~b. A nonstate government-owned hospital is owned or operated by a unit of government other than a state. The payment amount for a participating hospital is the hospital's proportionate share of the established pool of funds determined by dividing the hospital's payments for outpatient services provided to Medicaid patients during the most recent fiscal year by the total payments for outpatient services to Medicaid patients provided by all participating nonstate government-owned hospitals for the same fiscal year.~~

~~c. A payment made to a hospital under this provision when combined with other payments made under the State Plan shall not exceed the limit specified in 42 USC § 1396r-4(g). Any amount not included in a payment because of the operation of the preceding sentence shall be distributed to other participating hospitals in the same manner and subject to the same limitations as set forth above.~~

~~d. For the period from December 16, 2001, through May 13, 2002, aggregate payments to nonstate government-owned hospitals shall not exceed 150% of a reasonable estimate of the amount that would be paid for the services furnished by these hospitals under Medicare payment principles. For the period beginning May 14, 2002, aggregate payments to these hospitals shall not exceed 100% of a reasonable estimate of the amount that would~~

be paid for the services furnished by these hospitals under Medicare payment principles.

e. To determine the reasonable estimate of the amount that would be paid under Medicare payment principles, each hospital's outpatient cost to charge ratio will be calculated and applied to its Medicaid outpatient charges. The reasonable estimate will be the sum of the calculations for all hospitals. The calculation will use data from the last settled cost report for all nonstate government-owned hospitals at the beginning of the state fiscal year for which calculations are made. However, for state fiscal year 2002, only data from the last settled cost report at the beginning of state fiscal year 2003 will be used. Charges and Medicaid payments will be trended forward using the Virginia-specific DRI-hospital inflation factors. Additional adjustments will be made for any statutory changes in Medicare or Medicaid payments. The most recently available data on Medicaid DSH payments will be used.]

7. Supplemental payments to state government-owned hospitals for outpatient services.

a. In addition to payments for services set forth elsewhere in this State Plan, DMAS provides supplemental payments to [qualifying] state government-owned or operated hospitals for outpatient services provided to Medicaid patients on or after July 2, 2002. To qualify for a supplemental payment [,] the hospital must be [~~owned or operated by the state~~ part of a state academic health system or part of an academic health system that operates under a state authority].

b. The amount of the supplemental payment made to each [qualifying] hospital is determined by:

(1) Calculating [for each hospital] the [annual] difference between the [~~lower of the upper payment~~] limit [~~specified in 42 CFR 447.325 or the limit specified at 42 USC § 1396r-4(g)~~] attributed to each qualifying hospital calculated according to this subdivision 7d] and the amount otherwise actually paid for the services by the Medicaid program;

(2) Dividing the difference determined in [~~subdivision (1) of this~~] subdivision 7 b [(1) for each qualifying hospital] by the aggregate [~~upper payment limit amount~~] difference] for all such [qualifying] hospitals; and

(3) Multiplying the proportion determined in [~~subdivision (2) of this~~] subdivision 7 b [(2)] by the aggregate upper payment limit amount for all [~~such~~] state owned or operated] hospitals as determined in accordance with 42 CFR 447.321 less all payments made to such hospitals other than under this section.

[(4) A payment made to a hospital under this provision when combined with other payments made under the State Plan shall not exceed the limit specified at 42 USC § 1396r-4(g). Any amount not included in a payment because of the operation of the preceding sentence shall be distributed to other qualifying

hospitals in the same manner and subject to the same limitations as set forth above.]

c. Payments [for furnished services] under this section may be made in one or more installments at such times, within the fiscal year or thereafter, as is determined by DMAS.

[d. To determine the aggregate upper payment limit amount referred to in subdivision 7 b (3), the following methodology will be used. A ratio will be calculated for each hospital by dividing its Medicare payments by Medicare charges. This Medicare payment-to-charge ratio will be multiplied by the Medicaid charges for each hospital. The upper payment limit will be the sum of the product of that multiplication for all hospitals. The calculation will use data from the most recently settled cost report for all state government-owned hospitals at the beginning of the state fiscal year for which calculations are made. Charges will be trended forward using hospital-specific data if available. If not available, charges will be trended forward using the Virginia-specific DRI hospital inflation factors. Additional adjustments will be made for any program changes in Medicare or Medicaid payments. The most recently available data on Medicaid DSH payments will be used.]

12 VAC 30-80-30. Fee-for-service providers.

A. Payment for the following services, except for physician services, shall be the lower of the state agency fee schedule (12 VAC 30-80-190 has information about the state agency fee schedule) or actual charge (charge to the general public):

1. Physicians' services (12 VAC 30-80-160 has obstetric/pediatric fees). Payment for physician services shall be the lower of the state agency fee schedule or actual charge (charge to the general public), except that reimbursement rates for designated physician services when performed in hospital outpatient settings shall be 50% of the reimbursement rate established for those services when performed in a physician's office. The following limitations shall apply to emergency physician services.

a. Definitions. The following words and terms, when used in this subdivision 1, shall have the following meanings when applied to emergency services unless the context clearly indicates otherwise:

"All-inclusive" means all emergency service and ancillary service charges claimed in association with the emergency department visit, with the exception of laboratory services.

"DMAS" means the Department of Medical Assistance Services consistent with Chapter 10 (§ 32.1-323 et seq.) of Title 32.1 of the Code of Virginia.

"Emergency physician services" means services that are necessary to prevent the death or serious impairment of the health of the recipient. The threat to the life or health of the recipient necessitates the use of the most accessible hospital available that is equipped to furnish the services.

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"Recent injury" means an injury ~~which~~ *that* has occurred less than 72 hours prior to the emergency department visit.

b. Scope. DMAS shall differentiate, as determined by the attending physician's diagnosis, the kinds of care routinely rendered in emergency departments and reimburse physicians for nonemergency care rendered in emergency departments at a reduced rate.

(1) DMAS shall reimburse at a reduced and all-inclusive reimbursement rate for all physician services, including those obstetric and pediatric procedures contained in 12 VAC 30-80-160, rendered in emergency departments [~~which~~ *that*] DMAS determines are nonemergency care.

(2) Services determined by the attending physician to be emergencies shall be reimbursed under the existing methodologies and at the existing rates.

(3) Services determined by the attending physician [~~which~~ *that*] may be emergencies shall be manually reviewed. If such services meet certain criteria, they shall be paid under the methodology in subdivision 1 b (2) of this subsection. Services not meeting certain criteria shall be paid under the methodology in subdivision 1 b (1) of this subsection. Such criteria shall include, but not be limited to:

(a) The initial treatment following a recent obvious injury.

(b) Treatment related to an injury sustained more than 72 hours prior to the visit with the deterioration of the symptoms to the point of requiring medical treatment for stabilization.

(c) The initial treatment for medical emergencies including indications of severe chest pain, dyspnea, gastrointestinal hemorrhage, spontaneous abortion, loss of consciousness, status epilepticus, or other conditions considered life threatening.

(d) A visit in which the recipient's condition requires immediate hospital admission or the transfer to another facility for further treatment or a visit in which the recipient dies.

(e) Services provided for acute vital sign changes as specified in the provider manual.

(f) Services provided for severe pain when combined with one or more of the other guidelines.

(4) Payment shall be determined based on ICD-9-CM diagnosis codes and necessary supporting documentation.

(5) DMAS shall review on an ongoing basis the effectiveness of this program in achieving its objectives and for its effect on recipients, physicians, and hospitals. Program components may be revised subject to achieving program intent objectives, the accuracy and effectiveness of the ICD-9-CM code designations, and the impact on recipients and providers.

2. Dentists' services.

3. Mental health services including: (i) community mental health services; (ii) services of a licensed clinical psychologist; or (iii) mental health services provided by a physician.

a. Services provided by licensed clinical psychologists shall be reimbursed at 90% of the reimbursement rate for psychiatrists.

b. Services provided by independently enrolled licensed clinical social workers, licensed professional counselors or licensed clinical nurse specialists-psychiatric shall be reimbursed at 75% of the reimbursement rate for licensed clinical psychologists.

4. Podiatry.

5. Nurse-midwife services.

6. Durable medical equipment (DME).

a. The rate paid for all items of durable medical equipment except nutritional supplements shall be the lower of the state agency fee schedule that existed prior to July 1, 1996, less 4.5%, or the actual charge.

b. The rate paid for nutritional supplements shall be the lower of the state agency fee schedule or the actual charge.

c. Certain durable medical equipment used for intravenous therapy and oxygen therapy shall be bundled under specified procedure codes and reimbursed as determined by the agency. Certain services/durable medical equipment such as service maintenance agreements shall be bundled under specified procedure codes and reimbursed as determined by the agency.

(1) Intravenous therapies. The DME for a single therapy, administered in one day, shall be reimbursed at the established service day rate for the bundled durable medical equipment and the standard pharmacy payment, consistent with the ingredient cost as described in 12 VAC 30-80-40, plus the pharmacy service day and dispensing fee. Multiple applications of the same therapy shall be included in one service day rate of reimbursement. Multiple applications of different therapies administered in one day shall be reimbursed for the bundled durable medical equipment service day rate as follows: the most expensive therapy shall be reimbursed at 100% of cost; the second and all subsequent most expensive therapies shall be reimbursed at 50% of cost. Multiple therapies administered in one day shall be reimbursed at the pharmacy service day rate plus 100% of every active therapeutic ingredient in the compound (at the lowest ingredient cost methodology) plus the appropriate pharmacy dispensing fee.

(2) Respiratory therapies. The DME for oxygen therapy shall have supplies or components bundled under a service day rate based on oxygen liter flow rate or blood gas levels. Equipment associated with respiratory therapy may have ancillary components bundled with

the main component for reimbursement. The reimbursement shall be a service day per diem rate for rental of equipment or a total amount of purchase for the purchase of equipment. Such respiratory equipment shall include, but not be limited to, oxygen tanks and tubing, ventilators, noncontinuous ventilators, and suction machines. Ventilators, noncontinuous ventilators, and suction machines may be purchased based on the individual patient's medical necessity and length of need.

(3) Service maintenance agreements. Provision shall be made for a combination of services, routine maintenance, and supplies, to be known as agreements, under a single reimbursement code only for equipment [which that] is recipient owned. Such bundled agreements shall be reimbursed either monthly or in units per year based on the individual agreement between the DME provider and DMAS. Such bundled agreements may apply to, but not necessarily be limited to, either respiratory equipment or apnea monitors.

7. Local health services, including services paid to local school districts.

8. Laboratory services (other than inpatient hospital).

9. Payments to physicians who handle laboratory specimens, but do not perform laboratory analysis (limited to payment for handling).

10. X-Ray services.

11. Optometry services.

12. Medical supplies and equipment.

13. Home health services. Effective June 30, 1991, cost reimbursement for home health services is eliminated. A rate per visit by discipline shall be established as set forth by 12 VAC 30-80-180.

14. Physical therapy; occupational therapy; and speech, hearing, language disorders services when rendered to noninstitutionalized recipients.

15. Clinic services, as defined under 42 CFR 440.90.

16. *Supplemental payments to state government-owned [or operated] clinics.*

a. In addition to payments for clinic services specified elsewhere in this state plan, DMAS provides supplemental payments [~~to government-owned or operated clinics~~] for outpatient services provided to Medicaid patients on or after July 2, 2002. Clinic means a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. Outpatient services include those furnished by or under the direction of a physician, dentist or other medical professional acting within the scope of his license to an eligible individual. [Supplemental payments will be made to Children's Specialty Services, a state government-owned and operated clinic.]

~~[b. The amount of the supplemental payment made to each state government-owned or operated clinic is determined by:~~

~~(1) Calculating for each clinic the annual difference between the amount that would be paid for inpatient services provided to Medicaid eligibles under the Medicare program and the amount otherwise actually paid for the services by the Medicaid program;~~

~~(2) Dividing the difference determined in subdivision (1) of this subdivision 16 b for the clinic by the aggregate difference for all such clinics; and~~

~~(3) Multiplying the proportion determined in subdivision (2) of this subdivision 16 b by the aggregate upper payment limit amount for all such clinics as determined in accordance with 42 CFR 447.321 less all payments made to such clinics other than under this section.~~

b. The amount of the supplemental payment made to Children's Specialty Services is determined by calculating for all state government-owned or operated clinics the annual difference between the aggregate upper payment limit specified in 42 CFR 447.321 and determined according to the method described in subdivision 16 d and the amount otherwise actually paid for the services by the Medicaid program.]

c. Payments [for furnished services] made under this section may be made in one or more installments at such times, within the fiscal year or thereafter, as is determined by DMAS.

[d. To determine the aggregate upper payment limit, Medicaid payments to state government-owned or operated clinics will be divided by the "additional factor" whose calculation is described in Attachment 4.19-B, Supplement 4 (12 VAC 30-80-190 B) in regard to the state agency fee schedule for Resource Based Relative Value Scale (RBRVS). Medicaid payments will be estimated using payments for dates of service from the prior fiscal year adjusted for expected claim payments. Additional adjustments will be made for any program changes in Medicare or Medicaid payments.]

17. [~~(RESERVED-)~~Supplemental payments for services provided by Type I physicians.]

18. Supplemental payments to nonstate government-owned or operated clinics.

a. In addition to payments for clinic services specified elsewhere in [~~this state plan~~ the regulations], DMAS provides supplemental payments to [qualifying] nonstate government-owned or operated clinics for outpatient services provided to Medicaid patients on or after July 2, 2002. Clinic means a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. Outpatient services include those furnished by or under the direction of a physician, dentist or other medical professional acting within the scope of his license to an eligible individual. [A qualifying clinic is a clinic with estimated Medicaid payments in 2003 (including primary payments and copayments) of more than \$100,000 other

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than under this section and that serve areas covered by managed care prior to January 1, 1998.]

b. The amount of the supplemental payment made to each [qualifying] nonstate government-owned or operated clinic is determined by:

(1) Calculating for each clinic the annual difference between the [upper payment] limit [~~specified in 42 CFR 447.325~~ attributed to each clinic according to subdivision 18 d] and the amount otherwise actually paid for the services by the Medicaid program;

(2) Dividing the difference determined in [subdivision (1) of this] subdivision 18 b [(1)] for [the each qualifying] clinic by the aggregate difference for all such [qualifying] clinics; and

(3) Multiplying the proportion determined in subdivision (2) of this subdivision 18 b by the aggregate upper payment limit amount for all such clinics as determined in accordance with 42 CFR 447.321 less all payments made to such clinics other than under this section.

c. Payments [for furnished services] made under this section may be made in one or more installments at such times, within the fiscal year or thereafter, as is determined by DMAS.

[d. To determine the aggregate upper payment limit referred to in subdivision 18 b (3), Medicaid payments to nonstate government-owned or operated clinics will be divided by the "additional factor" whose calculation is described in Attachment 4.19-B, Supplement 4 (12 VAC 30-80-190 B) in regard to the state agency fee schedule for RBRVS. Medicaid payments will be estimated using payments for dates of service from the prior fiscal year adjusted for expected claim payments. Additional adjustments will be made for any program changes in Medicare or Medicaid payments.]

B. Hospice services payments must be no lower than the amounts using the same methodology used under Part A of Title XVIII, and take into account the room and board furnished by the facility, equal to at least 95% of the rate that would have been paid by the state under the plan for facility services in that facility for that individual. Hospice services shall be paid according to the location of the service delivery and not the location of the agency's home office.

[~~12 VAC 30-90-17. Additional payment to state government-owned or operated intermediate care facilities for the mentally retarded (ICF/MR).~~

~~In addition to payments for ICF/MR services set forth elsewhere in this State Plan, DMAS makes supplemental payments to state government-owned or operated ICFs/MR for services provided to Medicaid patients on or after July 2, 2002. DMAS uses the following methodology to calculate the additional Medicaid payments to state government-owned or operated ICFs/MR:~~

~~1. For each state fiscal year, DMAS calculates the maximum additional payments that it can make to all state government-owned or operated nursing facilities or ICFs-MR in conformance with 42 CFR 447.272.~~

~~2. DMAS determines the total Medicaid days reported by each state government-owned or operated ICF/MR for a fiscal period using cost reports from the most recent fiscal year for which all state government-owned or operated ICFs/MR have acceptable cost reports on file with DMAS.~~

~~3. DMAS divides the total Medicaid days for each participating state government-owned or operated ICF/MR by the total Medicaid days for all state government-owned or operated ICFs/MR to determine the supplementation factor for each.~~

~~4. For each state government-owned or operated ICF/MR, DMAS multiplies the facility's supplementation factor determined in subdivision 3 of this section by the total additional payment amount identified in subdivision 1 of this section to determine the additional payment to be made to each state government-owned or operated ICF/MR.~~

~~5. Payments under this section may be made in one or more installments at such times, within the fiscal year or thereafter, as determined by DMAS.]~~

[~~12 VAC 30-90-18. Additional payment to state government-owned or operated nursing facilities.~~

~~In addition to payments for nursing facility services set forth elsewhere in this State Plan, DMAS makes supplemental payments to state government-owned or operated nursing facilities for services provided to Medicaid patients on or after July 2, 2002. DMAS uses the following methodology to calculate the additional Medicaid payments to state government-owned or operated nursing facilities:~~

~~1. For each state fiscal year, DMAS calculates the maximum additional payment that it can make to all state government-owned or operated nursing facilities in conformance with 42 CFR 447.272.~~

~~2. DMAS determines the total Medicaid days reported by each state government-owned or operated nursing facility for a fiscal period using cost reports from the most recent fiscal year for which all state government-owned or operated nursing facilities have acceptable cost reports on file with DMAS.~~

~~3. DMAS divides the total Medicaid days for each state government-owned or operated nursing facility by the total Medicaid days for all state government-owned or operated nursing facilities to determine the supplementation factor for each.~~

~~4. For each state government-owned or operated nursing facility, DMAS multiplies the facility's supplementation factor determined in subdivision 3 of this section by the total additional payment amount identified in subdivision 1 of this section to determine the additional payment to be made to each state government-owned or operated nursing facility.~~

~~5. Payments under this section may be made in one or more installments at such times, within the fiscal year or thereafter, as is determined by DMAS.]~~

VA.R. Doc. No. R02-317; Filed December 8, 2003, 4:32 p.m.



TITLE 18. PROFESSIONAL AND OCCUPATIONAL LICENSING

BOARD OF AUDIOLOGY AND SPEECH-LANGUAGE PATHOLOGY

Title of Regulation: 18 VAC 30-20. Regulations of the Board of Audiology and Speech-Language Pathology (amending 18 VAC 30-20-10, 18 VAC 30-20-150, 18 VAC 30-20-170, 18 VAC 30-20-240, and 18 VAC 30-20-280).

Statutory Authority: § 54.1-2400 and Chapter 26 (§ 54.1-2600 et seq.) of Title 54.1 of the Code of Virginia.

Effective Date: January 28, 2004.

Agency Contact: Elaine J. Yeatts, Agency Regulatory Coordinator, Department of Health Professions, 6603 W. Broad Street, 5th Floor, Richmond, VA 23230-1717, telephone (804) 662-9918, FAX (804) 662-9114 or e-mail elaine.yeatts@dhp.state.va.us.

Summary:

The amendments (i) reduce the active engagement in the profession requirement for individuals licensed in other states who wish to become licensed in Virginia; (ii) update the accrediting bodies that certify competency; (iii) require that licensed audiologists and speech-language pathologists document their supervision of unlicensed assistants; and (iv) enable the board to license students in a doctoral program who have the equivalency of a master's degree.

Summary of Public Comments and Agency's Response: A summary of comments made by the public and the agency's response may be obtained from the promulgating agency or viewed at the office of the Registrar of Regulations.

REGISTRAR'S NOTICE: The proposed regulation was adopted as published in 19:6 VA.R. 954-958 December 2, 2002, with the changes identified below. Pursuant to § 2.2-4031 of the Code of Virginia, the adopted regulation is not published at length; however, the sections that have changed since publication of the proposed are set out.

18 VAC 30-20-10. [No change from proposed.]

18 VAC 30-20-150. [No change from proposed.]

18 VAC 30-20-170. Requirements for licensure.

A. The board may grant a license to an applicant who:

1. Holds a current and unrestricted Certificate of Clinical Competence in the area in which he seeks licensure issued by the American Speech-Language-Hearing Association, [certification issued by] the American Board of Audiology or any other accrediting body recognized by the board. Verification of currency shall be in the form of a certified letter from the American Speech-Language-Hearing Association or a recognized accrediting body issued within six months prior to licensure; and

2. Has passed the qualifying examination for the Certificate of Clinical Competence from an accrediting body recognized by the board within three years preceding the date of applying for licensure, or has held employment in the area been actively engaged in the respective profession for which he seeks licensure for one of the past three consecutive years or two of the past five consecutive years. [preceding the date of application]; or

B. The board may grant a license to an applicant who:

1. Holds a master's [degree] or its equivalent as determined by the board or a doctoral degree from a college or university whose audiology and speech-language program is regionally accredited by the American Speech-Language-Hearing Association or an equivalent accrediting body; and

2. Has passed a qualifying examination approved [as from an accrediting body] recognized by the board [~~The applicant shall have passed the examination~~] within three years preceding the date of applying for licensure in Virginia or [have has] been actively engaged in the respective profession during the 24 months immediately [for which he seeks licensure] for one of the past three consecutive years preceding the date of application.

C. The board may grant a license to an applicant as a school speech-language pathologist who:

1. Holds a master's degree in speech-language-pathology; and
2. Holds an endorsement in speech-language pathology from the Virginia Department of Education.

18 VAC 30-20-240. [No change from proposed.]

18 VAC 30-20-280. [No change from proposed.]

NOTICE: The forms used in administering 18 VAC 30-20, Regulations of the Board of Audiology and Speech-Language Pathology, are not being published due to the large number; however, the name of each form is listed below. The forms are available for public inspection at the Department of Health Professions, 6603 West Broad Street, Richmond, Virginia, or at the office of the Registrar of Regulations, General Assembly Building, 2nd Floor, Richmond, Virginia.

FORMS

[Application Checklist – Applicants by ASHA Certification (rev. 3/03).]

Application for [~~Licensure~~ a License to Practice by ASHA Certification] (rev. 7/97 [10/02 2003]).

[Application Checklist – Applicants by ABA Certification (rev. 3/03).]

Application for a License to Practice by ABA Certification (rev. 3/03).

Application Checklist – Applicants by Education/Examination (rev. 3/03).

Examination Application for a License to Practice (rev. 10/02).

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Application Checklist – Applicants for School Speech-Language Pathology License (rev. 3/03).]

Application for [a License as a] School Speech-Language Pathologist [Licensure] (rev. [~~11/99~~ 10/02]).

[Licensure] Reinstatement Application [for a License to Practice] (rev. [~~7/97~~ 10/02]).

[Endorsement Certification Form A (rev. 11/99).]

Renewal Notice and Application [, 2201] (rev. [~~5/00~~ 12/02]).

[*Renewal Notice and Application, 2202 (rev. 12/02).*]

Continued Competency Activity and Assessment Form (eff. 3/01).

VA.R. Doc. No. R02-144; Filed December 9, 2003, 3:05 p.m.

BOARD OF FUNERAL DIRECTORS AND EMBALMERS

Title of Regulation: 18 VAC 65-20. Regulations of the Board of Funeral Directors and Embalmers (amending 18 VAC 65-20-10, 18 VAC 65-20-50, 18 VAC 65-20-70, 18 VAC 65-20-170, 18 VAC 65-20-350, 18 VAC 65-20-400, 18 VAC 65-20-440, 18 VAC 65-20-570, 18 VAC 65-20-580, 18 VAC 65-20-590, and 18 VAC 65-20-700).

Statutory Authority: § 54.1-2400 and Chapter 28 (§ 54.1-2800 et seq.) of Title 54.1 of the Code of Virginia.

Effective Date: January 28, 2004.

Agency Contact: Elaine J. Yeatts, Agency Regulatory Coordinator, Department of Health Professions, 6603 W. Broad Street, 5th Floor, Richmond, VA 23230, telephone (804) 662-9918, FAX (804) 662-9114 or e-mail elaine.yeatts@dhp.state.va.us.

Summary:

The amendments establish criteria for locating a branch establishment, modify the requirements for a change of ownership, provide additional access to licensure by endorsement, clarify the scope of practice for courtesy card holders, and require persons who handle remains with a surface transportation and removal service registration to have OSHA training. In addition, amendments update requirements for a preparation room and its equipment and for documentation of embalming.

The following changes were made by the board in the adoption of final amendments:

1. Defines "branch" or "chapel" as a funeral service establishment that is affiliated with a licensed main establishment and that conforms to the requirements of § 54.1-2811 of the Code of Virginia;

2. Removes the identification requirements for a branch or chapel and no longer requires a written plan if the preparation of dead human bodies require that a body be transported between a main establishment, branch, or chapel and another such facility;

3. Clarifies that an applicant must possess credentials that are substantially similar to those required by Virginia at the time the person was initially licensed in another state; and

4. Clarifies that inventories of embalming and preparation materials must not only be in containers that are impervious to water and provide protection from contamination, but must also be stored in a manner that provides such protection.

Summary of Public Comments and Agency's Response: A summary of comments made by the public and the agency's response may be obtained from the promulgating agency or viewed at the office of the Registrar of Regulations.

18 VAC 65-20-10. Definitions.

Words and terms used in this chapter shall have the definitions ascribed in § 54.1-2800 of the Code of Virginia or in 16 CFR Part 453, Funeral Industry Practices, of the Federal Trade Commission, which is incorporated by reference in this chapter. In addition, the following words and terms when used in this chapter shall have the following meanings, unless the context clearly indicates otherwise:

"Branch" or "chapel" means a [~~secondary location or other facility where the practice of funeral services occurs, which is owned and operated by a main~~] funeral service establishment [that is affiliated with a licensed main establishment and that conforms with the requirements of § 54.1-2811 of the Code of Virginia].

"Courtesy card" means the card issued by the board which grants limited and restricted funeral service privileges in the Commonwealth to out-of-state funeral service licensees, funeral directors, and embalmers.

"Cremation urn" means a wood, metal, stone, plastic, or composition container or a container of other material, which is designed for encasing cremated ashes.

"Cremation vault" or "cremation outer burial container" means any container ~~which~~ that is designed for encasement of an inner container or urn containing cremated ashes. Also known as a cremation box.

"Establishment manager" means a funeral service licensee or licensed funeral director designated as the manager of record who is responsible for the direct supervision and management of a funeral service establishment or branch facility.

"FTC" means the Federal Trade Commission.

18 VAC 65-20-50. Posting of license.

A. Each licensee shall post an original or photocopy of his license in a place conspicuous to ~~the public, such as the arrangement office,~~ consumers of funeral services in each establishment or branch where he is employed.

B. The establishment license shall be posted in a place conspicuous to ~~the public, such as the arrangement office~~ consumers of funeral services.

18 VAC 65-20-70. Required fees.

A. The following fees shall apply for initial licensure or registration and for renewal of licensure or registration:

- 1. License to practice funeral service or as a funeral director or an embalmer \$150
- 2. Funeral service establishment license \$225
- 3. Surface transportation and removal service registration \$250
- 4. Courtesy card \$100
- 5. Crematory \$100
- 6. Waiver of full-time manager requirement \$100

B. Other fees.

- 1. Reinstatement fee for each year of licensure or registration expiration \$50
- 2. Change of manager or establishment name \$50
- 3. Verification of license or registration to another state \$50
- 4. Duplicate license, registration, or courtesy card \$25 \$15
- 5. Duplicate wall certificates \$50 \$25
- 6. Change of ownership \$100
- 7. Reinspection for change of location or ownership \$100
- 8. Application or renewal for continuing education provider \$200

18 VAC 65-20-170. Requirements for an establishment license.

A. No person shall maintain, manage, or operate a funeral service establishment in the Commonwealth, unless such establishment holds a license issued by the board. The name of the funeral service licensee or licensed funeral director designated by the ownership to be manager of the establishment shall be included on the license.

B. Except as provided in § 54.1-2810 of the Code of Virginia, every funeral service establishment and every branch or chapel of such establishment, regardless of how owned, shall have a separate establishment manager who is employed full time by the establishment for at least 40 hours a week.

C. At least 45 days prior to opening an establishment, an owner or licensed manager seeking an establishment license shall submit simultaneously a completed application, any additional documentation as may be required by the board to determine eligibility, and the applicable fee. An incomplete package will be returned to the licensee. A license shall not be issued until an inspection of the establishment has been completed and approved.

D. Within 30 days following a change of ownership, the owner or licensed manager shall notify the board, request a reinspection of the establishment, submit an application for a new establishment license *with documentation that identifies the new owner*, and pay the licensure and reinspection fees as required by 18 VAC 65-20-70. *Reinspection of the establishment may occur on a schedule determined by the board, but shall occur no later than one year from the date of the change.*

~~[E. Identification requirements for a branch or chapel.~~

~~1. The license of a branch or chapel shall clearly reflect the name of the main establishment.~~

~~2. The general price list and the itemized statement shall clearly state that the facility is a branch or chapel and identify the name of the main establishment.~~

~~3. All public informational materials or advertisements relating to services provided at or by the branch or chapel, either in print or electronic format, shall state that the facility is a branch or chapel and identify the name of the main establishment.~~

~~F. If the preparation of dead human bodies may require that a body be transported between a main establishment, branch, or chapel and another such facility, the following are also required:~~

~~1. A statement shall be given to the next of kin or designee, disclosing that the body may be transported for services for which a preparation room is necessary; and~~

~~2. The branch or chapel shall maintain on file and make available for inspection a written plan, detailing the method and approximate time required for transporting a dead human body to another location for purposes of embalming or in the event there is a need for services for which a preparation room is necessary.~~

~~E. The application for licensure of a branch or chapel shall specify the name of the main establishment.]~~

18 VAC 65-20-350. Requirements for licensure by reciprocity or endorsement.

A. Licenses for the practice of funeral service or its equivalent issued by other states, territories, or the District of Columbia may be recognized by the board and the holder of such license or licenses may be granted a license to practice funeral service within the Commonwealth, as follows:

1. Reciprocity. Licenses may be granted by reciprocity provided that the same privileges are granted by the other jurisdiction to Virginia funeral service licensees by the establishment of substantially similar licensure requirements and reciprocity agreements between the two jurisdictions; or

2. Endorsement. Licenses may be granted to applicants by the board on a case-by-case basis if the applicant holds a valid license for the practice of funeral service or its equivalent in another state, territory, or the District of Columbia and possesses credentials which are substantially similar to or more stringent than required by the Commonwealth for initial licensure [~~and the examinations and passing grades received by the applicant are equivalent to those required by the board~~] *at the time the applicant was initially licensed.*

B. An applicant for licensure by reciprocity or endorsement shall pass the Virginia State Board Examination.

18 VAC 65-20-400. Registration of surface transportation and removal services.

All persons applying to own or operate a surface transportation and removal service, according to requirements

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of § 54.1-2819 of the Code of Virginia, shall submit an application package for registration which shall include:

1. A completed and signed application;
2. The fee prescribed in 18 VAC 65-20-70 A 3; and
3. Additional documentation as may be required by the board to determine eligibility of the applicant, *including, but not limited to, evidence of training in the requirements of the Occupational Safety and Health Administration (OSHA).*

18 VAC 65-20-440. Courtesy cards.

A. An out-of-state person applying for a courtesy card pursuant to § 54.1-2801 B of the Code of Virginia shall hold a valid license for funeral service, funeral directing, or embalming in another state, territory, or the District of Columbia.

B. An applicant for a courtesy card shall submit:

1. A completed application and prescribed fee; and
2. Verification of a current license in good standing from the applicant's licensing authority.

C. *The holder of a Virginia courtesy card shall only engage in the practice for which he is currently licensed in another jurisdiction.*

18 VAC 65-20-500. Disciplinary action.

EDITOR'S NOTICE: The amendment to 18 VAC 65-20-500 that was proposed in 19:8 VA.R. 1168 December 30, 2002, was finalized in 19:19 VA.R. 2869 June 20, 2003, and became effective on July 2, 2003.

18 VAC 65-20-570. Condition of preparation room.

A. The preparation room or rooms shall be kept in a clean and sanitary condition at all times, subject to inspection.

B. Inventories of embalming and preparation materials shall ~~not be stored on the floor in the preparation room in a container [and in a manner] that [is makes them] impervious to water [or in a manner that and] protects them from contamination.~~

C. Any items or supplies not directly used in an embalming procedure shall not be stored in the preparation room.

18 VAC 65-20-570. Condition of preparation room.

A. The preparation room or rooms shall be kept in a clean and sanitary condition at all times, subject to inspection.

B. Inventories of embalming and preparation materials shall ~~not be stored on the floor in the preparation room in a container that is impervious to water or in a manner that protects them from contamination.~~

C. Any items or supplies not directly used in an embalming procedure shall not be stored in the preparation room.

18 VAC 65-20-580. Preparation room equipment.

The preparation room or rooms shall be equipped with:

1. A ventilation system which operates and is appropriate to the size and function of the room;
2. Running hot and cold water;
3. Flush or slop sink connected with public sewer or with septic tank where no public sewer is available;
4. Metal, *fiberglass* or porcelain morgue table;
5. Covered waste container;
6. Instruments and apparatus for the embalming process;
7. A means or method for the sterilization of reusable instruments by chemical bath or soak; autoclave (steam); or ultraviolet light;
8. Disinfectants and antiseptic solutions;
9. Clean gowns or aprons, preferably impervious to water;
10. Rubber gloves for each embalmer or trainee using the room;
11. ~~A hydroaspirator~~ *An electric aspirator* or ~~hydroaspirators~~ *hydroaspirator* equipped with a vacuum breaker;
12. An eye wash station *that is readily accessible*; and
13. A standard first aid kit which is immediately accessible outside the door to the preparation room.

18 VAC 65-20-590. Disposal of waste materials.

Disposal of all waste materials shall be in conformity with local, state, and federal law to avoid contagion and the possible spread of disease. *Upon inspection, the establishment shall provide evidence of compliance, such as a copy of a contract with a medical waste disposal company.*

18 VAC 65-20-700. Retention of documents.

The following shall apply to retention of embalming reports, price lists, and itemized statements:

1. Price lists shall be retained for one year after the date on which they are no longer effective;
2. Itemized statements shall be retained for one year from the date on which the arrangements were made;
3. Embalming reports shall be retained *at the location of the embalming* for one year after the date of the embalming;
4. Documents shall be maintained on the premises of the funeral establishment and made available for inspection; and
5. In instances where the funeral establishment is sold, documents shall be transferred to the new owner, unless the existing firm is relocating to a new facility.

VA.R. Doc. No. R02-73; Filed December 9, 2003, 2:55 p.m.

BOARD OF SOCIAL WORK

Title of Regulation: 18 VAC 140-20. Regulations Governing the Practice of Social Work (amending 18 VAC 140-20-105 and 18 VAC 140-20-150).

Statutory Authority: § 54.1-2400 of the Code of Virginia.

Effective Date: January 28, 2004.

Agency Contact: Elaine J. Yeatts, Agency Regulatory Coordinator, Department of Health Professions, 6603 W. Broad Street, Richmond, VA 23230, telephone (804) 662-9918, FAX (804) 662-9114 or e-mail elaine.yeatts@dhp.state.va.us.

Summary:

The amendments (i) update the reference to the National Federation of Societies for Clinical Social Work, Inc., to the Clinical Social Work Federation and (ii) limit to two years the period of time after cessation or termination of professional services that a social worker may not engage in sexual intimacies with a supervisee, resident, therapy patient, client, or those included in collateral therapeutic services.

Summary of Public Comment and Agency's Response: A summary of comments made by the public and the agency's response may be obtained from the promulgating agency or viewed at the Office of the Registrar of Regulations.

18 VAC 140-20-105. Continued competency requirements for renewal of an active license.

A. After April 25, 2003, licensed social workers and licensed clinical social workers shall be required to have completed a minimum of 30 contact hours of continuing education for each biennial licensure renewal. A minimum of two of those hours must pertain to the standards of practice and laws governing the profession of social work in Virginia, or the Code of Ethics of one of the social work professional associations listed under subdivision B 1 d.

1. The board may grant an extension for good cause of up to one year for the completion of continuing education requirements upon written request from the licensee prior to the renewal date. Such extension shall not relieve the licensee of the continuing education requirement.

2. The board may grant an exemption for all or part of the continuing education requirements due to circumstances beyond the control of the licensee such as temporary disability, mandatory military service, or officially declared disasters.

B. Hours may be obtained from a combination of board-approved activities in the following three categories:

1. Category I. Formally Organized Learning Activities. A minimum of 20 hours shall be documented in this category, which shall include one or more of the following:

a. Regionally accredited university or college academic courses in a behavioral health discipline. A maximum of 15 hours will be accepted for each academic course.

b. Continuing education programs offered by universities or colleges accredited by the Council on Social Work Education.

c. Workshops, seminars, conferences, or courses in the behavioral health field offered by federal, state or local social service agencies, public school systems or licensed health facilities and licensed hospitals.

d. Workshops, seminars, conferences or courses in the behavioral health field offered by an individual or organization that has been certified or approved by one of the following:

(1) The Child Welfare League of America and its state and local affiliates.

(2) The National Association of Social Workers and its state and local affiliates.

(3) The Association of Black Social Workers and its state and local affiliates.

(4) The Family Service Association of America and its state and local affiliates.

(5) The ~~National Federation of Societies for Clinical Social Work, Inc.~~ Federation and its state and local affiliates.

(6) Individuals or organizations who have been approved as continuing education sponsors by the Association of Social Work Boards or any state social work board.

2. Category II. Individual Professional Activities. A maximum of 10 of the required 30 hours may be earned in this category, which shall include one or more of the following:

a. Participation in an Association of Social Work Boards item writing workshop. (Activity will count for a maximum of two hours.)

b. Publication of a professional social work-related book or initial preparation/presentation of a social work-related course. (Activity will count for a maximum of 10 hours.)

c. Publication of a professional social work-related article or chapter of a book, or initial preparation/presentation of a social work-related in-service training, seminar or workshop. (Activity will count for a maximum of five hours.)

d. Provision of a continuing education program sponsored or approved by an organization listed under Category I. (Activity will count for a maximum of two hours and will only be accepted one time for any specific program.)

e. Field instruction of graduate students in a Council on Social Work Education-accredited school. (Activity will count for a maximum of two hours.)

f. Serving as an officer or committee member of one of the national professional social work associations listed under subdivision B 1 d of this section. (Activity will count for a maximum of two hours.)

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g. Attendance at formal staffings at federal, state or local social service agencies, public school systems or licensed health facilities and licensed hospitals. (Activity will count for a maximum of five hours.)

h. Independent or group study including listening to audio tapes, viewing video tapes, reading, professional books or articles. (Activity will count for a maximum of five hours.)

18 VAC 140-20-150. Professional conduct.

Persons licensed as social workers and clinical social workers shall:

1. Practice in a manner that is in the best interest of the public and does not endanger the public health, safety, or welfare.
2. Be able to justify all service rendered to clients as necessary for diagnostic or therapeutic purposes.
3. Practice only within the competency areas for which they are qualified by education or experience, or both.
4. Report to the board known or suspected violations of the laws and regulations governing the practice of social work.
5. Neither accept nor give commissions, rebates, or other forms of remuneration for referral of clients for professional services.
6. Ensure that clients are aware of fees and billing arrangements before rendering services.
7. Keep confidential their therapeutic relationships with clients and disclose client records to others only with written consent of the client, with the following exceptions: (i) when the client is a danger to self or others; or (ii) as required by law.
8. When advertising their services to the public, ensure that such advertising is neither fraudulent nor misleading.
9. Not engage in dual relationships with clients, former clients, supervisees, and supervisors that might compromise [~~the client's, former client's, or supervisee's~~] well-being, impair the social worker's or supervisor's objectivity and professional judgment or increase the risk of exploitation [~~This includes, to include~~], but is not limited to, such activities as counseling close friends, sexual partners, employees or relatives, and engaging in business relationships with clients. [~~Engaging in sexual intimacies with current clients or supervisees is prohibited. For at least two years after cessation or termination of professional services, licensees shall not engage in sexual intimacies with a therapy client or those included in collateral therapeutic services. Since sexual or romantic relationships are potentially exploitative, licensees shall bear the burden of demonstrating that there has been no exploitation. A client or supervisee's consent to, initiation of or participation in sexual behavior or involvement with a practitioner does not change the nature of the conduct nor lift the regulatory prohibition. Sexual contact or conduct of a sexual nature during the course of professional services and for a period of not less than two years following cessation or termination of professional services with a~~

client or those included in the provision of collateral therapeutic services shall be prohibited. Thereafter, the licensee shall bear the burden of demonstrating that there has been no exploitation regardless of that person's consent to, initiation of or participation in the sexual contact or conduct of a sexual nature with the practitioner.]

10. Maintain clinical records on each client. The record shall include identifying information to substantiate diagnosis and treatment plan, client progress, and termination. The clinical record shall be preserved for at least five years post termination.

11. Ensure that clients have provided informed consent to treatment.

NOTICE: The forms used in administering 18 VAC 140-20, Regulations Governing the Practice of Social Work, are not being published due to the number of pages; however, the name of each form is listed below. The forms are available for public inspection at the Board of Social Work, 6603 W. Broad Street, Richmond, Virginia, or at the office of the Registrar of Regulations, General Assembly Building, 2nd Floor, Richmond, Virginia.

FORMS

Registration of Supervision, ~~with Instructions~~ *Post-Graduate Degree Supervised Experience* (rev. ~~44/00~~ 12/02).

Social Worker Licensure Application (rev. ~~44/00~~ 12/02).

Clinical Social Worker Licensure Application (rev. ~~44/00~~ 12/02).

Verification of Clinical Supervision (rev. ~~44/00~~ 12/02).

Verification of Casework Management and Supportive Services (rev. ~~44/00~~ 12/02).

Renewal Notice and Application (rev. ~~44/00~~ 12/02).

Out of State Licensure Verification (rev. ~~44/00~~ 12/02).

Licensure Verification of Out-of-State Supervisor (rev. ~~44/00~~ 12/02).

Form for Reporting Social Work Attendance at Formal Staffing (~~eff. 44/00~~ rev. 12/02).

Form for Reporting Social Work Independent Study (~~eff. 44/00~~ rev. 12/02).

General Information for Licensure by Examination as a Licensed Social Worker, with Application Instructions (rev. ~~44/00~~ 12/02).

General Information for Licensure by Endorsement as a Licensed Social Worker, with Application Instructions (rev. ~~44/00~~ 12/02).

General Information for Licensure by Examination as a Clinical Social Worker, with Application Instructions (rev. ~~44/00~~ 12/02).

General Information for Licensure by Endorsement as a Clinical Social Worker, with Application Instructions (~~eff. 44/00~~ rev. 12/02).

Registration of Supervision Instructions (rev. 44/00 12/02).

VA.R. Doc. No. R02-184; Filed December 9, 2003, 2:56 p.m.

TITLE 22. SOCIAL SERVICES

STATE BOARD OF SOCIAL SERVICES

Title of Regulation: 22 VAC 40-250. Agency Placement Adoptions -- AREVA (amending 22 VAC 40-250-10 and 22 VAC 40-250-20).

Statutory Authority: §§ 63.2-217 and 63.2-900 of the Code of Virginia.

Effective Date: February 1, 2004.

Agency Contact: Brenda Kerr, Permanency Program Manager, Department of Social Services, 7 North 8th Street, Richmond, VA 23219, telephone (804) 726-7530, FAX (804) 726-7499, or e-mail brenda.kerr@dss.virginia.org.

Summary:

The amendments (i) make the AREVA registration criteria for children consistent with the changes made to the criteria for special needs and adoption subsidy (22 VAC 40-260); (ii) lengthen the timeframe for child registration following termination of parental rights from 30 to 60 days; (iii) delete obsolete language; and (iv) include reference to an automated adoption exchange.

Summary of Public Comments and Agency's Response: No public comments were received by the promulgating agency.

REGISTRAR'S NOTICE: The proposed regulation was adopted as published in 19:19 VA.R. 2807-2809 June 2, 2003, without change. Therefore, pursuant to § 2.2-4031 of the Code of Virginia, the text of the final regulation is not set out.

VA.R. Doc. No. R02-223; Filed December 9, 2003, 1:54 p.m.

Title of Regulation: 22 VAC 40-260. Agency Placement Adoptions -- Subsidy (amending 22 VAC 40-260-10 and 22 VAC 40-260-20).

Statutory Authority: §§ 63.2-217, 63.2-900 and 63.2-1303 of the Code of Virginia.

Effective Date: February 1, 2004.

Agency Contact: Brenda Kerr, Permanency Program Manager, Department of Social Services, 7 North 8th Street, Richmond, VA 23219, telephone (804) 726-7530, FAX (804) 726-7499, or e-mail brenda.kerr@dss.virginia.gov.

Summary:

The amendments (i) remove the requirement to feature a child in Virginia's Adoption Resource Exchange System (AREVA) photo listing for a period of 30 days to qualify for adoption subsidy; (ii) clarify that adoption subsidy agreements can be renegotiated when the adopted child

enters foster care or physical custody becomes the responsibility of the Commonwealth; and (iii) provide a right of appeal provision for adoptive parents and applicants to appeal agency decisions related to adoption assistance. The appeal provision is language taken from 22 VAC 40-270, which is being repealed. The appeal provision is narrower than the appeal provisions found in 22 VAC 40-270, which grants adoptive parents and applicants a right to appeal all service and policy related agency decisions. Since publication of the proposed amendments, a new provision is added to allow for child care to be paid as a maintenance payment.

Summary of Public Comment and Agency's Response: A summary of comments made by the public and the agency's response may be obtained from the promulgating agency or viewed at the Office of the Registrar of Regulations.

22 VAC 40-260-10. Definitions.

The following words and terms, when used in this chapter, shall have the following meaning, meanings unless the context clearly indicates otherwise:

"AFDC" means the Aid to Families with Dependent Children Program.

"Adoption" means a legal process in which a person's rights and duties toward birth parents are terminated and similar rights and duties are established with a new family.

"Adoption assistance agreement" means a written agreement between the agency and adoptive parents that is binding on both parties. An adoption assistance agreement may be for a federal subsidy, a state or local subsidy, a state or local subsidy, or a conditional subsidy.

"Agency" means a local Department of Public Welfare or Social Services.

"Agency placement adoption" means an adoption in which a child is placed in an adoptive home by an agency or child placing agency which has custody of the child.

"AREVA" means the Adoption Resource Exchange of Virginia which maintains a registry and photo-listing of children and families waiting for adoption.

"Child" means any person under 18 years of age.

"Child-placing agency" means any agency licensed to place children in foster homes or adoptive homes.

"Child with special needs" means any child in the custody of an agency or child-placing agency who is legally free for adoption:

1. The state has determined is unlikely to return home because of termination of parental rights.

For whom it has been determined that the child is unlikely to be adopted within a reasonable period of time due to one or more factors including, but not limited to 2. Has individual characteristics that make the child hard to place including:

a. Physical, mental, or emotional condition existing prior to adoption;

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b. Hereditary tendency, congenital problem or birth injury leading to substantial risk of future disability;

c. Individual circumstances of the child related to age, racial or ethnic background or close relationship with one or more siblings or foster parents.

3. *Has had reasonable efforts made to place without subsidy.*

~~2-~~ 4. For whom the above conditions were present at the time of adoption, but not diagnosed until after entry of the final order of adoption, and ~~no more than one year has elapsed since the diagnosis is not more than 12 months old.~~

"Department" means the Virginia Department of Social Services.

"Finalization of the adoption" means the court process of sanctioning the adoption which begins with the filing of a petition and ends with the entry of the final order of adoption.

"Maintenance payments" means payments made to adoptive parents on behalf of a child with special needs to help with daily living expenses.

"Nonrecurring expenses" means expenses of adoptive parents directly related to the adoption of a child with special needs including, but not limited to, attorney fees directly related to the finalization of the adoption; transportation; court costs; and reasonable and necessary fees of child placing agencies.

"Special service payments" means payments or services provided to help in meeting the child's physical, mental, emotional, or dental needs.

"SSI" means Supplemental Security Income.

"Subsidy/adoption assistance" means a money payment or services provided to adoptive parents on behalf of a child with special needs.

22 VAC 40-260-20. Subsidy.

A. An adoption assistance agreement shall be executed by the agency or child placing agency for all children who have been determined eligible for subsidy.

B. *Determining the child's eligibility before legal adoption.*

1. *Basic eligibility. The child must be:*

a. *Under 18 years of age;*

b. *In the custody of a local department of social services or licensed, private child placing agency at the time the petition for adoption is filed; and*

c. *Placed by the local department of social services or licensed, private child placing agency with the prospective adoptive family for the purpose of adoption, except for those situations in which the child has resided for 18 months with foster parents who file a petition for adoption under § 63.2-1229 of the Code of Virginia.*

~~A-~~ 2. *Determining that the child's eligibility for subsidy child has special needs.* ~~1. In determining the child's eligibility for subsidy before legal adoption, The agency or child-placing agency shall determine that:~~

~~a. Determine that the child is a child with special needs. A special needs child is any child in the custody of an agency or child placing agency who is free for adoption, but unlikely to be adopted within a reasonable time due to one or more of the following conditions including, but not limited to:~~

~~a. The child cannot be returned home because parental rights are terminated.~~

~~b. The child has individual characteristics that make the child hard to place for adoption due to one or more of the following:~~

~~(1) Physical, mental, or emotional condition existing before legal adoption;~~

~~(2) Hereditary tendency, congenital problem or birth injury that could lead to a future disability, verified by a medical/psychological statement;~~

~~(3) Is six years of age or older;~~

~~(4) Is a member of a minority or mixed racial heritage;~~

~~(5) Is a member of a sibling group that should not be separated; and~~

~~(6) Has significant emotional ties with foster parents with whom the child has resided for at least 12 months; when the adoption is in the best interest of the child and when the subsidy is necessary to consummate the adoption by these foster parents.~~

~~b. Make c. Reasonable efforts have been made to first place the child with appropriate adoptive parents without subsidy. A reasonable effort:~~

~~(1) Shall be made except when it would be against the best interest of the child because of factors such as the existence of significant emotional ties with foster parents;~~

~~(2) Shall be considered made if: the child has been registered with AREVA and featured in the photolisting.~~

~~(a) Local recruitment efforts have been undertaken and documented; or~~

~~(b) Requirements for registration with AREVA have been met; and~~

~~(c) The child has been featured in the AREVA photo listing for a period of 30 days or other special recruitment efforts have been undertaken by AREVA and an appropriate family has not been identified for the child.~~

~~2. In order for a child to be eligible after legal adoption:~~

C. *Determining the child's eligibility after legal adoption.*

~~a-~~ 1. The child must have a physical, mental or emotional condition that was present at the time of adoptive placement; or

~~b-~~ 2. The need for subsidy results from a hereditary tendency, congenital problem, or birth injury; and

~~e. 3. In either a or b no more than one year has elapsed since the diagnosis was made both subdivisions 1 and 2 of this subsection, there is a medical or psychological diagnosis that is not more than 12 months old.~~

~~B. D.~~ Determining the type of agreement for which the child is eligible. The types of subsidy for which a child can be eligible are:

1. A federal ~~or state~~ subsidy. This type of subsidy is used for children whose foster care expenses are paid from federal and state funds. A federal/~~state~~ subsidy agreement shall be executed for any special needs child who meets eligibility requirements for AFDC or SSI.

2. A state subsidy. This type of subsidy is used for children whose foster care expenses are paid from ~~state and local Comprehensive Services Act pool~~ funds.

3. A conditional subsidy:

a. Shall be provided for any child with special needs, whose foster care expenses are paid from ~~state and local Comprehensive Services Act pool~~ funds, when payments and services are not needed at the time of placement but may be needed later. It is granted upon the request of the adoptive parents when a child:

- (1) Has a physical, mental or emotional disability at the time of placement;
- (2) Has a hereditary tendency, congenital problem or birth injury;
- (3) Could develop emotional or other problems resulting from separation from birth parents, placement in foster care, or adoption;
- (4) May need help later with daily living expenses.

b. Does not involve money payments or services. It is an agreement that allows the adoptive parent or parents to apply for a state ~~or local~~ subsidy after the final order of adoption;

~~c. Does not require that reasonable efforts first be made to place the child with an appropriate family without subsidy;~~

~~d. c.~~ Commits the agency to providing a state subsidy when the adoptive parent or parents apply, if it is determined that the need is related to one of the conditions described in subdivision 3 a of this subsection;

~~e. d.~~ Does not require annual certification.

~~C. E.~~ Determining the types of payment to be made. *Adoption assistance payments must be negotiated with the adoptive family taking into consideration the needs of the child and the circumstances of the family. In considering the family's circumstances, income shall not be the sole factor. Family and community resources must be explored to help defray the costs of adoption assistance.*

There are three types of payment which shall be made on behalf of a child who is eligible for subsidy. The amount of payments made and services provided shall not exceed what

would have been paid or provided had the child remained in foster care. The types of payment include:

1. Maintenance payments[∴]

a. A maintenance payment shall be approved for all children who are eligible for subsidy, except those for whom a conditional subsidy will be provided, unless the adoptive parent or parents indicate that a payment is not needed ~~or it is determined through negotiation that the payment is not needed.~~

b. The amount of the payment shall be negotiated with the adoptive parents taking into consideration the needs of the child and circumstances of the adoptive parents.

~~c. The negotiated maintenance rate shall be approved by the department prior to signing the Adoption Assistance Agreement.~~

~~d. c.~~ Maintenance payments shall not be reduced lower than the amount specified in the initial subsidy agreement, unless requested by the adoptive parents.

~~e. d.~~ Increases in the amount of payment shall be made when *the child is receiving the maximum allowable basic maintenance payment and:*

- (1) A child reaches a higher age grouping, as specified in foster care policy for maintenance payments;
- (2) Statewide increases are approved for foster care maintenance payments.

~~f. e.~~ Payments shall be made directly to the adoptive parent or parents on a monthly basis.

[~~f. Child care may be purchased with a maintenance payment, if needed by the adoptive parents.]~~

2. Special service payments[∴]

a. A special service payment is used to help in meeting the child's physical, mental, emotional, or *nonroutine* dental needs. *The special service payment must be directly related to the child's individual characteristic that makes the child hard to place or a physical, mental or emotional condition that existed at the time of placement but was not identified before the final order of adoption.*

b. Types of expenses that are appropriate to be paid include:

- (1) Medical, surgical, or dental;
- (2) Equipment such as prosthetics, braces, crutches, hearing aids, ~~eyeglasses~~, etc.;
- (3) Individual tutoring or remedial educational sessions, books or equipment;
- (4) Psychological and psychiatric evaluations and treatment;
- (5) Speech, physical, and occupational therapy;
- (6) Premiums for a major medical insurance policy for a child, if the child is not covered by a family policy; and

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- (7) Special services provided directly to the child by the adoptive parents. These are services provided by the parent to meet the special needs of a child. They are distinct from basic maintenance and supervision. The parents shall be qualified by experience or specific training to perform such services. This item may be paid in addition to a maintenance payment.
- c. Special service payments may be provided, at the discretion of the agency, for other services needed to maintain the same level of service that the child received in foster care.
- d. A special service payment may be used for children eligible for Title XIX and the Social Services Block Grant (SSBG) to supplement expenses not covered by Medicaid or when SSBG funds are not available or do not provide adequate coverage.
- e. Payments for special services are negotiated with the adoptive parents taking into consideration:
- (1) The special needs of the child;
 - (2) Alternative resources available to fully or partially defray the cost of meeting the child's special needs; and
 - (3) The circumstances of the adoptive family. In considering the family's circumstances, income shall not be the sole factor.
- f. Special service payments may be made directly to the providers of service or through the adoptive parents. A bill or receipt shall be submitted before payment. The agency shall not be responsible for bills or receipts submitted later than six months after the end of the month in which the service was rendered.
- ~~g. Providers shall be approved according to requirements for purchase of service specified by the Department of Social Services. The rate of payment shall not exceed the prevailing community rate.~~
3. One time only payments[:] Adoptive parents shall be reimbursed, upon request, for the nonrecurring expenses of adopting a ~~special needs~~ child *with special needs*.
- a. Nonrecurring expenses shall include:
- (1) Attorney fees directly related to the finalization of the adoption, ~~not to exceed a reasonable rate set by the Department of Social Services;~~
 - (2) Transportation and other expenses incurred by adoptive parents related to placement of the child. Expenses may be paid for more than one visit;
 - (3) Court costs related to filing an adoption petition; and
 - (4) Reasonable and necessary fees of adoption child placing agencies, ~~not to exceed a reasonable rate set by the Department of Social Services.~~
- b. An adoption assistance agreement shall be signed and shall specify the services to be provided under this section.
- c. Payment of nonrecurring expenses may begin as soon as the adoption assistance agreement has been signed and the child is placed in the adoptive home. Payment may be made directly to providers of service or to the adoptive parents for expenses they have incurred.
- d. A bill or receipt shall be submitted before payment can be made. The agency shall not be responsible for bills or receipts submitted later than six months after the end of the month in which the expense was incurred.
- ~~D. F. Applying for subsidy.~~
1. Procedures for the child whose eligibility is established before legal adoption.
 - a. The adoption assistance agreement:
 - (1) Shall be executed within 90 days of receipt of the application for adoption assistance;
 - (2) Shall be signed before entry of the final order of adoption;
 - (3) Shall specify the amount of payment and the services to be provided, including Title XIX and SSBG services;
 - (4) May be adjusted with the concurrence of the adoptive parents, in the event of changes in the needs of the child;
 - (5) Shall remain in effect regardless of the state of which the adoptive parents are residents at any given time; and
 - (6) The interests of the child shall be protected through the Interstate Compact on Adoption and Medical Assistance, should the adoptive parents and child move to another state while the agreement is effective.
 2. Procedures for the child whose eligibility is established after legal adoption. The application procedures are the same as for the child whose eligibility is established before adoption except:
 - a. The application shall be submitted within one year of ~~the~~ a diagnosis;
 - b. The application shall be for a state subsidy.
- ~~E. G. Maintaining responsibility.~~
1. The adoptive parent or parents shall:
 - a. Submit annually to the agency or child placing agency an affidavit which certifies that:
 - (1) The child for whom they are receiving subsidy remains in their care;
 - (2) They are legally responsible for supporting the child; and, if applicable,
 - (3) The child's condition requiring subsidy continues to exist.
 - b. Submit copies of all bills or receipts for special service payments made directly to the adoptive parents.
 2. The agency or child-placing agency shall:
-

a. Maintain responsibility for any payment or services identified in the agreement, regardless of where the family resides;

a. b. Inform prospective adoptive parents of the child's eligibility for subsidy. This shall include a full disclosure of the services and payments for which the child is or may be eligible;

b. c. Notify adoptive parent or parents who are receiving subsidy that the annual affidavit is due. The notification shall be sent to the adoptive parent or parents two months before the affidavit is due;

c. d. Inform adoptive parent or parents, in writing, that they have the right to appeal decisions relating to the child's eligibility for subsidy and decisions relating to payments and services to be provided.

~~F.~~ H. Terminating the subsidy agreement. The adoption assistance agreement:

1. Shall be terminated when the child reaches the age of 18 unless the child has:

- a. A physical or mental disability; or
- b. An educational delay ~~resulting from a physical or mental disability~~. This shall include educational delays resulting from a child's foster care circumstances. *The maintenance payment may be continued for a child who is turning 18 during his senior year of school, if the child is expected to graduate by the end of school year in which he turns 18.*

[~~e.~~] If a child has one of the conditions in [~~subdivisions~~] a and b above, the agreement shall be continued until the child reaches the age of 21[~~;~~]

2. Shall not be terminated before the child's 18th birthday without the consent of the adoptive parents unless[~~;~~]

- a. It is determined that the child is no longer receiving financial support from the adoptive parents; [~~e~~]
- b. The adoptive parent or parents are no longer legally responsible for the child; or
- c. The child's condition requiring subsidy no longer exists.

3. Shall not be terminated if the child's condition improves but could deteriorate again. In this case, the agreement shall be suspended without a payment, rather than terminated.

[~~4.~~] *When a child receiving adoption subsidy enters foster care or physical custody becomes the responsibility of the state, the local agency may renegotiate the adoption assistance agreement with the adoptive parent(s). Any renegotiated adoption assistance agreement must receive concurrence from all parties to the agreement.*

I. Appeals.

1. Adoptive applicants and adoptive parents shall have the right to appeal adoption subsidy/assistance decisions related to:

a. The lack of or shortage of subsidy/ adoption assistance because the agency failed to present to adoptive parents relevant facts known by the agency regarding the child prior to adoption finalization;

b. Failure of the agency to inform the parents of the child's eligibility for subsidy/adoption assistance;

c. Agency decisions related to the child's eligibility for subsidy/adoption assistance, subsidy payments and services, and changing or terminating a subsidy agreement; and

d. Failure of the agency to comply with state laws, policies, and procedures for approving adoptive homes.

2. Appeals shall be processed in accordance with procedures established by the Virginia Board of Social Services.

VA.R. Doc. No. R02-224; Filed December 9, 2003, 1:52 p.m.

Title of Regulation: **22 VAC 40-270. Agency Placement Adoptions -- Appeals (REPEALED).**

Statutory Authority: §§ 63.2-217 and 63.2-900 of the Code of Virginia.

Effective Date: February 1, 2004.

Agency Contact: Brenda Kerr, Permanent Program Manager, Department of Social Services, 7 North 8th Street, Richmond, VA 23219, telephone (804) 726-7530, FAX (804) 726-7499, or e-mail brenda.kerr@dss.virginia.gov.

Summary:

This regulation provides guidance on the appeal rights of adoptive applicants and adoptive parents. This action repeals the regulation. An appeals provision is added to 22 VAC 40-260, Agency Placement Adoptions--Subsidy.

The repeal of this regulation eliminates for adoptive parents and applicants a right to appeal service and policy related issues that include, but are not limited to, such provisions as (i) failure of the agency to provide full, factual information that the agency has about the child, except information that would reveal the identity of the child's family of origin and (ii) agency decisions related to approval of the family as a prospective adoptive home.

Summary of Public Comment and Agency Response: No public comments were received by the promulgating agency.

VA.R. Doc. No. R02-225; Filed December 9, 2003, 1:55 p.m.

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Title of Regulation: 22 VAC 40-675. Personnel Policies for Local Departments of Social Services (adding 22 VAC 40-675-10 through 22 VAC 40-675-220).

Statutory Authority: §§ 63.2-217 and 63.2-219 of the Code of Virginia.

Effective Date: February 1, 2004.

Agency Contact: Phyllis Sisk, Acting Director, Division of Human Resources Management, Department of Social Services, 730 East Broad Street, Richmond, Virginia 23219, telephone (804) 726-7902, FAX (804) 726-7028 or e-mail lak900@dss.state.va.us.

Summary:

The regulations establish personnel policies in local departments of social services and provide an additional legal basis for policies and practices in local departments of social services. Many of the policies are required as a condition for continued receipt of federal grants. The regulation addresses classification and compensation, recruitment and selection, employee status and benefits, employee performance evaluation, equal employment opportunity, standards of conduct, grievance procedures, and other employee relations practices.

Summary of Public Comments and Agency's Response: A summary of comments made by the public and the agency's response may be obtained from the promulgating agency or viewed at the office of the Registrar of Regulations.

REGISTRAR'S NOTICE: The repropoed regulation was adopted as published in 19:18 V.A.R. 2635-2662 May 19, 2003, with the changes identified below. Pursuant to § 2.2-4031 of the Code of Virginia, the adopted regulation is not published at length; however, the sections that have changed since publication of the repropoed are set out.

CHAPTER 675.
PERSONNEL POLICIES FOR LOCAL DEPARTMENTS OF
SOCIAL SERVICES.

PART I.
GENERAL PROVISIONS.

22 VAC 40-675-10. Definitions.

The following words and terms when used in this chapter shall have the following meanings unless the context clearly indicates otherwise:

"Administrative manual" means the Administrative Manual for Local Departments of Social Services Human Resource Management, which outlines the personnel policies and procedures.

"Board" means the State Board of Social Services.

"Classification" means the systematic grouping of positions based on shared characteristics.

"Class specifications specification" means a detailed statement that defines describes the characteristic elements of each classification title and identifies the factors that relate to that particular classification duties and KSAs.

~~"Commission" means the Workers' Compensation Commission.~~

"Commissioner" means the Commissioner of the Virginia Department of Social Services, his designee or authorized representative.

~~"Compensation" means rate of pay, based upon level of work performed and supervision given or received.~~

~~"Compensation schedule and plan" means DSS' classification and pay plan for local jurisdictions. This classification and pay plan has salary grades and pay steps of intervening increments from the minimum to maximum established for each grade. Classification titles are linked to a salary grade on the schedule by use of factors for ranking and comparing positions.~~

"Department" means the Virginia State Department of Social Services.

~~"DSS' DHRM" means the department's Division of Human Resources Management.~~

~~"Exempt" means not subject to the overtime provisions of the Fair Labor Standards Act.~~

"Deviate" means to adopt all or portions of the local jurisdiction personnel policies.

"Jurisdiction" or "local jurisdiction" means the city, county, or town under which the local department is a governmental unit.

"KSA" means a knowledge, skill, or ability needed to perform a position.

~~"Local board" means the local board of public welfare or social services in each county and city, as provided in Article 1 (§ 63.1-38 et seq.) of Chapter 3 of Title 63.1 of the Code of Virginia representing one or more counties or cities.~~

"Local compensation plan" is the locally developed pay plan that lists classifications, salary grades, and pay steps of intervening increments from the minimum to the maximum amounts established for each grade, and includes other pay actions.

~~"Local department" or "local agency" means any one of the local departments department of social services or public welfare throughout the Commonwealth, as provided in Article 1 (§ 63.1-38 et seq.) of Chapter 3 of Title 63.1 of the Code of Virginia of any city or county of this Commonwealth.~~

"Local director" means the director or superintendent his designated representative of any of the local departments department of social services or public welfare the city or county.

~~"Local hiring authority" means the local director, local board, or a designee with authorization to employ staff.~~

~~"Local jurisdiction" means any of the local cities or counties with which the local department and local board are affiliated.~~

"Merit system plan" means those rules and regulations promulgated adopted by the state board in the development and operation of a system of personnel administration meeting requirements of the federal Department of Health and Human

Services as relates to compliance with federal merit system standards set forth in the Code of Federal Regulations (5 CFR Part 900).

~~"On call" means constantly accessible to receive and respond to child protective service complaints on an emergency basis outside of the local department.~~

~~"Recruitment announcement" means the job vacancy posting that contains the position title and number along with other pertinent information, including type of position; salary; position expiration date, if applicable; special requirements or preferences, if any; a brief duties and responsibilities paragraph; entry-level knowledge, skill, and ability statements (KSAs); announcement period closing date; and mailing address.~~

~~"Recruitment announcement period" means the period of time, usually 10 workdays, during which applicants may apply for a position.~~

~~"Referral list" means the list prepared by DSS' DHRM that contains the names of applicants whom the local department may further consider in order to determine which applicants will be offered an interview.~~

~~"State board" means the Virginia Board of Social Services.~~

"Salary range" means salary grades and pay steps of intervening increments from the minimum to the maximum established for each grade, which includes reimbursable and nonreimbursable steps.

"Statewide [State [Classification Plan classification plan]" means DSS' statewide the department's classification plan that consists of an approved number of positions classifications and their corresponding class groups, salary grades, classification codes, equal employment opportunity codes and effective dates. The plan lists class specifications according to class code, occupational group, effective date, salary grade, and EEO code. Local departments select applicable classes based upon need and in conjunction with prescribed standards for allocating positions.

"WCA" means the Virginia Workers' Compensation Act.

"State [Compensation Plan compensation plan]" means the department's pay plan, which provides local departments a basis to develop local compensation plans.

22 VAC 40-675-20 through 22 VAC 20-675-40. [No change from proposed.]

22 VAC 40-675-50. Adoption of specific policies of the local jurisdiction.

A. Local boards may adopt specific local jurisdictional policies instead of using the state policies. A local department, upon approval by the local board, may request to deviate from state policies by adopting specific local jurisdiction policies instead of using personnel policies and procedures outlined in the Administrative Manual. The following local policy options may be requested on the Local Policy Request [~~form~~ Form]:

1. Performance evaluation;
2. Standards of conduct;

3. Leave policies;
4. Holiday schedule;
5. Inclement weather;
6. Probationary period; or
7. Layoff.

B. Local policy options also exist for classification and compensation, and affirmative action, and the grievance procedure. Requests for deviation from state policies shall be submitted consistent with the requirements of this section.

C. When the local board department wants to exercise one of the allowable options, it must obtain required approvals and submit the Local Policy Request Form to the Employee Relations Manager of DSS' DHRM. DHRM will provide its analysis to the state board required forms to the department in accordance with the Administrative Manual. The commissioner will provide his analysis to the board.

D. When policy changes, the local department shall submit a Local Policy Request Form to the department.

PART II.
STATE CLASSIFICATION AND COMPENSATION.

22 VAC 40-675-60. Preparation and explanation of the review process State [Classification Plan classification plan].

A. ~~The local director shall submit an updated copy of the human resource policy record no later than October 31 of each odd-numbered year. The local director shall:~~

- ~~1. Indicate the city or county.~~
- ~~2. Check each item to indicate whether the local department follows the policy contained in the administrative manual or the local policy of the jurisdiction.~~
- ~~3. Date and sign the form.~~
- ~~4. Prepare the form in triplicate and reproduce locally using the format in the administrative manual.~~

B. ~~The local department shall retain one copy and send the other two copies to the employee relations manager in DSS' DHRM.~~

- ~~1. DSS' DHRM will review the policy record to ensure that each local policy has been properly approved at a previous time on the Local Policy Request Form.~~
- ~~2. The policy record will be signed and returned to the local department as official notification of the human resource policies currently in effect.~~

C. ~~When policy changes occur between normal reporting periods, they must be reported to DSS' DHRM. If the change is to request adoption of a local policy instead of a state policy, then the Local Policy Request Form must be submitted to the state board through DSS' DHRM. If a state policy is requested instead of a previously approved local policy, state board approval must be obtained by submissions through DSS' DHRM. The [State Classification Plan state classification plan] consists of a broad range of approved classifications~~

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and accompanying specifications for use by the local departments to develop their local compensation plans to administer the programs set forth in Title 63.2 of the Code of Virginia.

PART II.

POSITION CLASSIFICATION AND COMPENSATION.

22 VAC 40-675-70. Commissioner's responsibilities.

A. The commissioner shall establish the [~~State Classification Plan~~ state classification plan] and shall submit the plan to the board for approval.

B. The commissioner shall maintain the [~~State Classification Plan~~ state classification plan] to ensure that it has the appropriate numbers and types of classifications to meet the needs of local departments.

22 VAC 40-675-80. State [~~Compensation Plan~~ compensation plan].

A. The board shall approve a [~~State Compensation Plan~~ state compensation plan] to ensure that it has the appropriate numbers and types of classifications to meet the needs of local departments.

B. The board shall review the [~~State Compensation Plan~~ state compensation plan] as needed.

C. Amendments to the [~~State Compensation Plan~~ state compensation plan] shall be presented to the board for approval.

D. The department shall advise local departments of all changes to the [~~State Compensation Plan~~ state compensation plan] and any mandates that require local department action.

22 VAC 40-675-90. Local compensation plans.

A. A local department, upon approval by the local board, shall have flexibility in developing the local compensation plan to select salary ranges within the approved [~~State Compensation Plan~~ state compensation plan] that are suitable to local situations. The range for each class shall provide local minimum and maximum rates and intervening steps. The local plan shall ensure that local minimum salary rates do not fall below the [~~State Compensation Plan~~ state compensation plan] minimum salary for that classification.

B. A local compensation plan shall include policies and procedures for awarding salary increments, [~~conversion,~~] merit increases, special compensation for child and adult protective service work, employee or position status changes, and any other type of approved increases. Salary determinations shall be rendered in a fair and consistent manner to ensure equal pay for equal work.

C. All requested position actions by local departments must be reviewed and approved by the department prior to implementation.

D. Midyear changes to the local compensation plan must be submitted to the department for review and approval.

E. Local compensation policies and practices shall comply with federal and state laws including the federal Fair Labor

Standards Act (29 USC §§ 201-219), the Administrative Manual and procedures provided by the department.

22 VAC 40-675-100. [No change from proposed.]

22 VAC 40-675-110. Deviations from [~~State Classification or Compensation Plans~~ state classification or compensation plans].

A. The board may approve local department's request for deviation from the [~~State Classification and Compensation Plan~~ state classification plan and compensation plans].

B. Deviation requests may be either for classification, classification and compensation or compensation only.

C. Local departments shall submit required forms as specified in the Administrative Manual when requesting deviation from the [~~State Classification and Compensation Plan~~ state classification plan and compensation plans].

22 VAC 40-675-120. Sanctions.

A. Policies and practices by the local departments are subject to review or audit by the department.

B. Reviews may include but not be limited to the assessment and analysis of personnel data, records, reports, systems [,] and feedback from local department employees.

C. When the department finds that a local department has not complied with or has violated the provisions of this regulation, the department may impose financial sanctions or require reimbursement of funds. Funds may be withheld until such time as deemed necessary for the proper administration of the local compensation plan.

PART III.

RECRUITMENT AND SELECTION OF LOCAL DEPARTMENT EMPLOYEES.

22 VAC 40-675-130. General hiring provision.

A. Recruitment, selecting and advancing employees shall be on the basis of their relative ability, knowledge and skills, including open consideration of qualified applicants for original appointment assuring fair treatment of applicants and employees in all aspects of personnel administration and with proper regard to their privacy and constitutional rights as citizens. This fair treatment principle includes compliance with the federal equal employment opportunity and nondiscrimination laws.

B. The department shall determine the application process and employment forms to be used by all applicants for original appointment, promotion, demotion, transfer [,] and reemployment.

C. In accordance with § 63.2-325 of the Code of Virginia, the commissioner shall provide a list of eligible candidates for the position of local director to the local board or other appropriate appointing authority.

D. The board shall place the responsibility of the final selection process of employees with the local director and local board.

E. Local departments adopting local jurisdiction personnel plans shall follow the provisions of the city, county or town of which they are a governmental unit.

PART IV.
EMPLOYEE STATUS.

22 VAC 40-675-140. Employee status in the merit system plan.

A. Status defines the employee's permanency in the system as it relates to benefits and the use of grievance policies.

B. The types of employee status included in the merit system plan are probationary, nonprobationary, restricted, temporary [,] and emergency.

C. Local departments shall provide benefits in accordance with the requirements of the Administrative Manual.

22 VAC 40-675-150 through 22 VAC 40-675-190. [No change from proposed.]

PART VIII.
GRIEVANCE PROCEDURE.

22 VAC 40-675-200. Employee grievance procedure.

Local departments not included in their jurisdiction's grievance procedure shall develop their own in accordance with the Administrative Manual. This grievance [procedure] shall be consistent with the provisions of Chapter 10 (§ 2.2-1000 et seq.) of Title 2.2 of the Code of Virginia.

PART IX.
OTHER EMPLOYEE RELATIONS POLICIES.

22 VAC 40-675-210. Political activity.

A. No local department employee shall make use of his official authority or influence to:

1. Interfere with or affect the result of a nomination or election to office;
2. Directly or indirectly coerce, command or advise a state or local officer or employee to pay, lend or contribute anything of value to a [~~part~~ party], committee, organization, agency or person for political purposes; or
3. Be a candidate for public elective office in a partisan primary, general or special election.

B. The local department's provisions on political activity are consistent with the federal Hatch Act (5 USC §§ 1501-1509) and facilitate effective control of prohibited political activity by employees.

C. In general, the Hatch Act covers officers or employees of a state or local department if their principle employment is in connection with an activity that is financed in whole or in part by loans or grants made by a federal agency. An employee subject to political activity laws continues to be covered by these laws and regulations while on annual leave, sick leave, leave without pay, administrative leave or furlough.

D. Local boards shall adopt these provisions or, instead, adopt the provisions of the local governmental jurisdiction consistent with the federal Hatch Act.

22 VAC 40-675-220. [No change from proposed.]

NOTICE: The forms used in administering 22 VAC 40-675, Personnel Policies for Local Departments of Social Services, are not being published; however, the name of each form is listed below. The forms are available for public inspection at the Department of Social Services, Division of Human Resources Management, 730 East Broad Street, Richmond, Virginia, or at the office of the Registrar of Regulations, General Assembly Building, 2nd Floor, Richmond, Virginia.

FORMS

Local Policy Request Form (eff. 9/00).

Self-Analysis Audit for Deviations (eff. 9/00).

~~*Service Rating of Local Director/Superintendent by Local Board and Regional Director (eff. 10/99).*~~

~~*Local Employee Performance Evaluation Form (eff. 10/99).*~~

~~*Sample Written Notice Form (eff. 4/00).*~~

Human Resource Policy Record.

[DOCUMENTS DOCUMENT] INCORPORATED BY REFERENCE

~~[*Local Agency Compensation Plan, Virginia Department of Human Resource Management, revised December 1, 2000.*]~~

Administrative Manual for Local Departments of Social Services, Virginia Department of Social Services, revised September 2000.

VA.R. Doc. No. R01-196; Filed April 29, 2003, 2:32 p.m.



EMERGENCY REGULATIONS

TITLE 12. HEALTH

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Titles of Regulations: **12 VAC 30-50. Amount, Duration and Scope of Medical and Remedial Care Services (amending 12 VAC 30-50-210).**

12 VAC 30-80. Methods and Standards for Establishing Payment Rates; Other Types of Care (amending 12 VAC 30-80-40).

12 VAC 30-130. Amount, Duration and Scope of Selected Services (adding 12 VAC 30-130-1000).

Statutory Authority: §§ 32.1-324 and 32.1-325 of the Code of Virginia.

Effective Dates: January 4, 2004, through January 3, 2005.

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Preamble:

This regulatory action is mandated by the Virginia Appropriation Act (the 2003 Acts of Assembly, Chapter 1042 Item 325 ZZ, subparts 1-6).

The purpose of this action is to implement a preferred drug list and prior authorization program for pharmacy services provided to Medicaid fee-for-service clients. For those therapeutic classes of drugs subject to the preferred drug list program, a preferred drug is one that meets the safety, clinical efficacy, and pricing standards employed by the Pharmacy and Therapeutics Committee. Nonpreferred drugs are those that were reviewed by the Pharmacy and Therapeutics Committee and not included on the preferred drug list. The nonpreferred drugs require prior authorization prior to dispensing. The Pharmacy and Therapeutics Committee may also recommend prior authorization requirements or clinical guidance regarding preferred drugs or other drugs. This action also establishes the parameters for action by the Pharmacy and Therapeutics Committee as well as the department's contractor for pharmacy services benefits management. The goal of the program is to improve the quality of pharmaceutical services and to reduce the significant increases in the cost of prescription drugs in the Medicaid fee-for-service program.

12 VAC 30-50-210. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

A. Prescribed drugs.

1. Drugs for which Federal Financial Participation is not available, pursuant to the requirements of § 1927 of the Social Security Act (OBRA 90 § 4401), shall not be covered.

2. Nonlegend drugs shall be covered by Medicaid in the following situations:

- a. Insulin, syringes, and needles for diabetic patients;
- b. Diabetic test strips for Medicaid recipients under 21 years of age;
- c. Family planning supplies;
- d. Designated categories of nonlegend drugs for Medicaid recipients in nursing homes; and
- e. Designated drugs prescribed by a licensed prescriber to be used as less expensive therapeutic alternatives to covered legend drugs.

3. Legend drugs are covered for a maximum of a 34-day supply per prescription per patient with the exception of the drugs or classes of drugs identified in 12 VAC 30-50-520. FDA-approved drug therapies and agents for weight loss, when preauthorized, will be covered for recipients who meet the strict disability standards for obesity established by the Social Security Administration in effect on April 7, 1999, and whose condition is certified as life threatening, consistent with Department of Medical Assistance Services' medical necessity requirements, by the treating physician. For prescription orders for which quantity exceeds a 34-day supply, refills may be dispensed in sufficient quantity to fulfill the prescription order within the limits of federal and state laws and regulations.

~~4. Notwithstanding the provisions of § 32.1-87 of the Code of Virginia, and in compliance with the provision of § 4401 of the Omnibus Reconciliation Act of 1990, § 1927(e) of the Social Security Act as amended by OBRA 90, and pursuant to the authority provided for under § 32.1-325 A of the Code of Virginia, prescriptions for Medicaid recipients for multiple source drugs subject to 42 CFR 447.332 shall be filled with generic drug products unless the physician or other practitioners so licensed and certified to prescribe drugs certifies in his own handwriting "brand necessary" for the prescription to be dispensed as written. Prescriptions for Medicaid recipients for multiple source drugs subject to 42 CFR 447.332 shall be filled with generic drug products unless the physician or other practitioners so licensed and certified to prescribe drugs certifies in his own handwriting "brand necessary" for the prescription to be dispensed as written or unless the drug class is subject to the Preferred Drug List.~~

5. New drugs shall be covered in accordance with the Social Security Act § 1927(d) (OBRA 90 § 4401).

6. The number of refills shall be limited pursuant to § 54.1-3411 of the Drug Control Act.

7. Drug prior authorization.

- a. Definitions. The following words and terms used in these regulations shall have the following meaning unless the context clearly indicates otherwise:

~~"Board" means the Board for Medical Assistance Services.~~

"Clinical data" means drug monographs as well as any pertinent clinical studies, including peer review literature.

"Committee" means the Medicaid Prior Authorization Advisory Committee.

"Complex drug regimen" means treatment or course of therapy that typically includes multiple medications, comorbidities and/or caregivers.

"Department" or "DMAS" means the Department of Medical Assistance Services.

"Director" means the Director of Medical Assistance Services.

"Drug" shall have the same meaning, unless the context otherwise dictates or the board otherwise provides by regulation, as provided in the Drug Control Act (§ 54.1-3400 et seq. of the Code of Virginia).

b. Medicaid Prior Authorization Advisory Committee; membership. The Medicaid Prior Authorization Committee shall consist of 11 members to be appointed by the board. Five members shall be physicians, at least three of whom shall care for a significant number of Medicaid patients; four shall be pharmacists, two of whom shall be community pharmacists; one member shall be a consumer of mental health services; and one shall be a Medicaid recipient.

(1) A quorum for action of the committee shall consist of six members.

(2) The members shall serve at the pleasure of the board; vacancies shall be filled in the same manner as the original appointment.

(3) The board shall consider nominations made by the Medical Society of Virginia, the Old Dominion Medical Society, the Psychiatric Society of Virginia, the Virginia Pharmaceutical Association, the Virginia Alliance for the Mentally Ill, and the Virginia Mental Health Consumers Association when making appointments to the committee.

(4) The committee shall elect its own officers, establish its own procedural rules, and meet as needed or as called by the board, the director, or any two members of the committee. The department shall provide appropriate staffing to the committee.

c. Duties of the committee.

(1) The committee shall make recommendations to the board regarding drugs or categories of drugs to be subject to prior authorization, prior authorization requirements for prescription drug coverage and any subsequent amendments to or revisions of the prior authorization requirements. The board may accept or reject the recommendations in whole or in part, and may amend or add to the recommendations, except that the board may not add to the recommendation of drugs and categories of drugs to be subject to prior authorization.

(2) In formulating its recommendations to the board, the committee shall not be deemed to be formulating regulations for the purposes of the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia). The committee shall, however, conduct public hearings prior to making recommendations to the board. The committee shall give 30 days' written notice by mail of the time and place of its hearings and meetings to any manufacturer whose product is being reviewed by the committee and to those manufacturers who request of the committee in writing that they be informed of such hearings and meetings. These persons shall be afforded a reasonable opportunity to be heard and present information. The committee shall give 30 days' notice of such public hearings to the public by publishing its intention to conduct hearings and meetings in the Calendar of Events of The Virginia Register of Regulations and a newspaper of general circulation located in Richmond.

(3) In acting on the recommendations of the committee, the board shall conduct further proceedings under the Administrative Process Act.

d. Prior authorization of prescription drug products; coverage.

(1) The committee shall review prescription drug products to recommend prior authorization under the state plan. This review may be initiated by the director, the committee itself, or by written request of the board. The committee shall complete its recommendations to the board within no more than six months from receipt of any such request.

(2) Coverage for any drug requiring prior authorization shall not be approved unless a prescribing physician obtains prior approval of the use in accordance with regulations promulgated by the board and procedures established by the department.

(3) In formulating its recommendations to the board, the committee shall consider the potential impact on patient care and the potential fiscal impact of prior authorization on pharmacy, physician, hospitalization and outpatient costs. Any proposed regulation making a drug or category of drugs subject to prior authorization shall be accompanied by a statement of the estimated impact of this action on pharmacy, physician, hospitalization and outpatient costs.

(4) The committee shall not review any drug for which it has recommended or the board has required prior authorization within the previous 12 months, unless new or previously unavailable relevant and objective information is presented.

(5) Confidential proprietary information identified as such by a manufacturer or supplier in writing in advance and furnished to the committee or the board according to this subsection shall not be subject to the disclosure requirements of the Virginia Freedom of Information Act (§ 2.2-3700 et seq. of the Code of Virginia). The board shall establish by regulation the

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~~means by which such confidential proprietary information shall be protected.~~

~~e. Immunity. The members of the committee and the board and the staff of the department shall be immune, individually and jointly, from civil liability for any act, decision, or omission done or made in performance of their duties pursuant to this subsection while serving as a member of such board, committee, or staff provided that such act, decision, or omission is not done or made in bad faith or with malicious intent.~~

~~f. Annual report to joint commission. The committee shall report annually to the Joint Commission on Health Care regarding its recommendations for prior authorization of drug products.~~

"Emergency supply" means a 72-hour supply of the prescribed medication that is dispensed if the physician is not available to consult with the pharmacist, including after hours, weekends, holidays or other criteria defined by the P&T Committee and DMAS.

"Nonpreferred drugs" means those drugs that were reviewed by the Pharmacy and Therapeutics Committee and not included on the preferred drug list. Nonpreferred drugs may be prescribed but require prior authorization prior to dispensing to the patient.

"Pharmacy and Therapeutics Committee (P&T Committee)" or "committee" means the committee formulated to review therapeutic classes, conduct clinical reviews of specific drugs, recommend additions or deletions to the preferred drug list, and perform other functions as required by the department.

"Preferred drug list (PDL)" means the list of drugs that meet the safety, clinical efficacy, and pricing standards employed by the P&T Committee and adopted by the department that may be prescribed and dispensed in the Virginia Medicaid fee-for-service program.

"Prior authorization" as it relates to the PDL, means the process of reviewing drugs, which are not on the preferred drug list or other drugs as recommended by the Pharmacy and Therapeutics Committee, to determine if medically justified.

"State supplemental rebate" means any cash rebate that offsets Virginia Medicaid expenditure and that supplements the federal rebate. State supplemental rebate amounts shall be calculated in accordance with Virginia Supplemental Rebate Agreement and Addenda.

"Therapeutic class" means a grouping of medications sharing the same Specific Therapeutic Class Code (GC3) within the Federal Drug Data File published by First Data Bank, Inc.

b. Medicaid Pharmacy and Therapeutics Committee.

1. The department shall utilize a Pharmacy and Therapeutics Committee (the P&T Committee) to assist in the development and ongoing administration of the preferred drug list and other pharmacy program issues. The committee may adopt bylaws that set out its make

up and functioning. A quorum for action of the committee shall consist of seven members.

2. Vacancies on the committee shall be filled in the same manner as original appointments. The department shall appoint individuals for the committee that assures a cross-section of the physician and pharmacy community.

c. Duties of the committee. The committee shall receive and review clinical and pricing data related to the drug classes. The committee's medical and pharmacy experts shall make recommendations to DMAS regarding various aspects of the pharmacy program. For the preferred drug list program, the committee shall select those drugs to be deemed preferred that are safe, clinically effective, as supported by available clinical data, and meet pricing standards. Cost effectiveness or any pricing standard shall be considered only after a drug is determined to be safe and clinically effective.

d. In formulating its recommendations to the department, the committee shall not be deemed to be formulating regulations for the purposes of the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia).

e. Pursuant to 42 USC § 1396r-8(b)(3)(D), information disclosed to the department or to the committee by a manufacturer or wholesaler which discloses the identity of a specific manufacturer or wholesaler and the pricing information regarding the drugs by such manufacturer or wholesaler is confidential and shall not be subject to the disclosure requirements of the Virginia Freedom of Information Act (§ 2.2-3700 et seq. of the Code of Virginia).

f. Immunity. The members of the committee and the staff of the department and the contractor shall be immune, individually and jointly, from civil liability for any act, decision, or omission done or made in performance of their duties pursuant to this subsection while serving as a member of such board, committee, or staff provided that such act, decision, or omission is not done or made in bad faith or with malicious intent.

g. Pharmacy prior authorization program. Pursuant to § 1927 of the Act and 42 CFR 440.230, the department shall require the prior authorization of certain specified legend drugs. For those therapeutic classes of drugs subject to the preferred drug list program, drugs not included in the DMAS preferred drug list shall be subject to prior authorization. The department also may require prior authorization of other drugs only if recommended by the P&T Committee. Providers who are licensed to prescribe legend drugs shall be required to obtain prior authorization for all nonpreferred drugs or other drugs as recommended by the P&T Committee.

h. Prior authorization shall consist of prescription review by a licensed pharmacist or pharmacy technician to ensure that all predetermined clinically appropriate criteria, as established by the P&T Committee relative to each therapeutic class, have been met before the prescription may be dispensed. Prior authorization shall be obtained through a call center staffed with appropriate

clinicians, or through written or electronic communications (e.g., faxes, mail). Responses by telephone or other telecommunications device within 24 hours of a request for prior authorization shall be provided. The dispensing of a 72-hour emergency supply of the prescribed drug shall be permitted and dispensing fees shall be paid to the pharmacy for such emergency supply.

i. The preferred drug list program shall include: (i) provisions for an expedited review process of denials of requested prior authorization by the department; (ii) consumer and provider education, (iii) training and information regarding the preferred drug list both prior to implementation as well as ongoing communications, to include computer and website access to information and multilingual material.

j. Appeals for denials of prior authorization shall be addressed pursuant to 12 VAC 30-110-10, Part I, Client Appeals.

k. Exclusion of protected groups from pharmacy preferred drug list prior authorization requirements. The following groups of Medicaid eligibles shall be excluded from pharmacy prior authorization requirements: individuals enrolled in hospice care, services through PACE or pre-PACE programs; persons having comprehensive third party insurance coverage; minor children who are the responsibility of the juvenile justice system; and refugees who are not otherwise eligible in a Medicaid covered group.

l. State supplemental rebates. The department has the authority to seek supplemental rebates from drug manufacturers. The contract regarding supplemental rebates shall exist between the manufacturer and the Commonwealth. Rebate agreements between the Commonwealth and a pharmaceutical manufacturer shall be separate from the federal rebates and in compliance with federal law, §§ 1927(a)(1) and 1927(a)(4) of the Social Security Act (Act). All rebates collected on behalf of the Commonwealth shall be collected for the sole benefit of the state share of costs. One hundred percent (100%) of the supplemental rebates collected on behalf of the state shall be remitted to the state. Supplemental drug rebates received by the Commonwealth in excess of those required under the national drug rebate agreement will be shared with the federal government on the same percentage basis as applied under the national drug rebate agreement.

8. Coverage of home infusion therapy. This service shall be covered consistent with the limits and requirements set out within home health services (12 VAC 30-50-160). Multiple applications of the same therapy (e.g., two antibiotics on the same day) shall be covered under one service day rate of reimbursement. Multiple applications of different therapies (e.g., chemotherapy, hydration, and pain management on the same day) shall be a full service day rate methodology as provided in pharmacy services reimbursement.

B. Dentures. Dentures are provided only as a result of EPSDT and subject to medical necessity and preauthorization requirements specified under Dental Services.

C. Prosthetic devices.

1. Prosthetic services shall mean the replacement of missing arms, legs, eyes, and breasts and the provision of any internal (implant) body part. Nothing in this regulation shall be construed to refer to orthotic services or devices or organ transplantation services.

2. Artificial arms and legs, and their necessary supportive attachments, implants and breasts are provided when prescribed by a physician or other licensed practitioner of the healing arts within the scope of their professional licenses as defined by state law. This service, when provided by an authorized vendor, must be medically necessary and preauthorized for the minimum applicable component necessary for the activities of daily living.

3. Eye prostheses are provided when eyeballs are missing regardless of the age of the recipient or the cause of the loss of the eyeball. Eye prostheses are provided regardless of the function of the eye.

D. Eyeglasses. Eyeglasses shall be reimbursed for all recipients younger than 21 years of age according to medical necessity when provided by practitioners as licensed under the Code of Virginia.

12 VAC 30-80-40. Fee-for-service providers: pharmacy.

Payment for pharmacy services shall be the lowest of items 1 through 5 (except that items 1 and 2 will not apply when prescriptions are certified as brand necessary by the prescribing physician in accordance with the procedures set forth in 42 CFR 447.331 (c) if the brand cost is greater than the Centers for Medicare and Medicaid Services (CMS) upper limit of or VMAC cost) subject to the conditions, where applicable, set forth in subdivisions 6 and 7 of this section:

1. The upper limit established by the CMS for multiple source drugs pursuant to 42 CFR 447.331 and 447.332, as determined by the CMS Upper Limit List plus a dispensing fee. If the agency provides payment for any drugs on the HCFA Upper Limit List, the payment shall be subject to the aggregate upper limit payment test.

2. The Virginia Medicaid Maximum Allowable Cost (VMAC) established by the Virginia Department of Medical Assistance Services to be inclusive of appropriate multiple source and specific high cost drugs plus a dispensing fee. Multiple source drugs may include but are not limited to Food and Drug Administration-rated products such as drugs established by a Virginia Voluntary Formulary (VVF) drugs, Federal Upper Limit Drugs and any other state or federally approved listing. "Multisource drugs" means covered outpatient drugs for which there are two or more drug products that:

- a. Are included in the Centers for Medicare and Medicaid Services' state drug rebate program;
- b. Have been approved by the Federal Food and Drug Administration (FDA);
- c. Are included in the Approved Products with Therapeutic Equivalence Evaluations as generically equivalent; and

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- d. Are sold or marketed in Virginia.
3. The Estimated Acquisition Cost (EAC) which shall be based on the published Average Wholesale Price (AWP) minus a percentage discount established by the General Assembly (as set forth in subdivision 8 of this section) or, in the absence thereof, by the following methodology set out in subdivisions a through c below.
- a. Percentage discount shall be determined by a statewide survey of providers' acquisition cost.
- b. The survey shall reflect statistical analysis of actual provider purchase invoices.
- c. The agency will conduct surveys at intervals deemed necessary by DMAS.
4. (Reserved.)
5. The provider's usual and customary charge to the public, as identified by the claim charge.
6. Payment for pharmacy services will be as described above; however, payment for legend drugs will include the allowed cost of the drug plus only one dispensing fee per month for each specific drug. Exceptions to the monthly dispensing fees shall be allowed for drugs determined by the department to have unique dispensing requirements. The dispensing fee of \$3.75 (effective July 1, 2003) shall remain in effect.
7. The Program pays additional reimbursement for unit dose dispensing system of dispensing drugs. DMAS defines its unit dose dispensing system coverage consistent with that of the Board of Pharmacy of the Department of Health Professions (18 VAC 110-20-420). This service is paid only for patients residing in nursing facilities. Reimbursements are based on the allowed payments described above plus the unit dose per capita fee to be submitted by the pharmacy for unit dose dispensing services to a nursing home resident. Only one service fee per month may be submitted by the pharmacy for each patient receiving unit dose dispensing services. The maximum allowed drug cost for specific multiple source drugs will be the lesser of: either the VMAC, based on the 60th percentile or maximum cost level, as identified by the state agency or CMS' upper limits as applicable. All other drugs will be reimbursed at drug costs not to exceed the estimated acquisition cost determined by the state agency. The original per capita fee shall be determined by a DMAS analysis of costs related to such dispensing, and shall be reevaluated at periodic intervals for appropriate adjustment.
8. Determination of EAC was the result of a report by the Office of the Inspector General that focused on appropriate Medicaid marketplace pricing of pharmaceuticals based on the documented costs to the pharmacy. An EAC of AWP minus 10.25% shall become effective July 1, 2002.
- The dispensing fee of \$3.75 (effective July 1, 2003) shall remain in effect, creating a payment methodology based on the previous algorithm (least of 1 through 5 of this subsection above) plus a dispensing fee where applicable.
9. Home infusion therapy.

a. The following therapy categories shall have a pharmacy service day rate payment allowable: hydration therapy, chemotherapy, pain management therapy, drug therapy, total parenteral nutrition (TPN). The service day rate payment for the pharmacy component shall apply to the basic components and services intrinsic to the therapy category. Submission of claims for the per diem rate shall be accomplished by use of the HCFA 1500 claim form.

b. The cost of the active ingredient or ingredients for chemotherapy, pain management and drug therapies shall be submitted as a separate claim through the pharmacy program, using standard pharmacy format. Payment for this component shall be consistent with the current reimbursement for pharmacy services. Multiple applications of the same therapy shall be reimbursed one service day rate for the pharmacy services. Multiple applications of different therapies shall be reimbursed at 100% of standard pharmacy reimbursement for each active ingredient.

10. Supplemental Rebate Agreement. Based on the requirements in § 1927 of the Act, the state has the following policies for the supplemental drug rebate program for Medicaid recipients:

a. The model supplemental rebate agreement between the state and drug manufacturers for drugs provided to Medicaid recipients, submitted to CMS on September 23, 2003, and entitled Virginia Supplemental Drug Rebate Agreement and Addenda has been authorized by CMS.

b. Supplemental drug rebates received by the state in excess of those required under the national drug rebate agreement will be shared with the federal government on the same percentage basis as applied under the national drug rebate agreement.

c. Prior authorization requirements found in § 1927(d)(5) of the Social Security Act have been met (if this assurance is not already included elsewhere in the State Plan).

d. Nonpreferred drugs are those that were reviewed by the Pharmacy and Therapeutics Committee and not included on the preferred drug list. Nonpreferred drugs will be made available to Medicaid beneficiaries through prior authorization.

12 VAC 30-130-1000. Pharmacy services prior authorization.

Definitions. The following words and terms used in these regulations shall have the following meaning unless the context clearly indicates otherwise:

"Clinical data" means drug monographs as well as any pertinent clinical studies, including peer review literature.

"Complex drug regimen" means treatment or course of therapy that typically includes multiple medications, comorbidities and/or caregivers.

"Contractor" means an independent contractor that implements, and administers, pursuant to its contract, the

department's pharmacy prior authorization programs as set out in the Title XIX State Plan.

"Department" or "DMAS" means the Virginia Department of Medical Assistance Services.

"Drug" shall have the same meaning, unless the context otherwise dictates or the board otherwise provides by regulation, as provided in the Drug Control Act (§ 54.1-3400 et seq. of the Code of Virginia).

"Emergency supply" means a 72-hour supply of the prescribed medication that is dispensed if the physician is not available to consult with the pharmacist, including after hours, weekends, holidays or other criteria defined by the P&T Committee and DMAS.

"Grandfather clause" means procedure by which selected therapeutic classes or drugs as designated by the P&T Committee may be automatically approved if the patient is currently and appropriately receiving the drug.

"Nonpreferred drugs" means those drugs that were reviewed by the Pharmacy and Therapeutics Committee and not included on the preferred drug list. Nonpreferred drugs may be prescribed but require prior authorization prior to dispensing to the patient.

"Pharmacy and Therapeutics Committee (P&T Committee)" or "committee" means the committee formulated to review therapeutic classes, conduct clinical reviews of specific drugs, recommend additions or deletions to the preferred drug list, and perform other functions as required by the department. The Pharmacy and Therapeutics Committee shall be composed of 8 to 12 members, including the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services, or his designee. Other members shall be selected or approved by the department. The membership shall include a ratio of physicians to pharmacists of 2:1. Physicians on the committee shall be licensed in Virginia, one of whom shall be a psychiatrist, and one of whom specializes in care for the aging. Pharmacists on the committee shall be licensed in Virginia, one of whom shall have clinical expertise in mental health drugs, and one of whom has clinical expertise in community-based mental health treatment.

"Preferred Drug List (PDL)" means the list of drugs that meet the safety, clinical efficacy, and pricing standards employed by the P&T Committee and adopted by the department that may be prescribed and dispensed in the Virginia Medicaid fee-for-service program.

"Prior authorization" as it relates to the PDL, means the process of reviewing drugs, which are not on the preferred drug list or other drugs as recommended by the Pharmacy and Therapeutics Committee, to determine if medically justified.

"State supplemental rebate" means any cash rebate that offsets Virginia Medicaid expenditure and that supplements the federal rebate. State supplemental rebate amounts shall be calculated in accordance with Virginia Supplemental Drug Rebate Agreement and Addenda.

"Therapeutic Class" means a grouping of medications sharing the same Specific Therapeutic Class Code (GC3) within the Federal Drug Data File published by First Data Bank, Inc.

A. DMAS shall operate, in conjunction with the Title XIX State Plan for Medical Assistance (12 VAC 30-50-210 et seq.) a program of prior authorization of pharmacy services. This program shall include, but not necessarily be limited to, the use of a preferred drug list.

B. Medicaid Pharmacy and Therapeutics Committee.

1. The department shall utilize a Pharmacy and Therapeutics Committee (the P&T Committee) to assist in the development and ongoing administration of the preferred drug list and other pharmacy program issues. The committee may adopt bylaws that set out its make up and functioning. A quorum for action of the committee shall consist of seven members.

2. Vacancies on the committee shall be filled in the same manner as original appointments. The department shall appoint individuals for the committee that assures a cross-section of the physician and pharmacy community.

3. Duties of the committee.

a. The committee shall receive and review clinical and pricing data related to the drug classes. The committee's medical and pharmacy experts shall make recommendations to DMAS regarding various aspects of the pharmacy program. For the preferred drug list program, the committee shall select those drugs to be deemed preferred that are safe, clinically effective, as supported by available clinical data, and meet pricing standards. Cost-effectiveness or any pricing standard shall be considered only after a drug is determined to be safe and clinically effective. The committee shall recommend to the department:

(i) Which therapeutic classes of drugs should be subject to the preferred drug list program and prior authorization requirements;

(ii) Specific drugs within each therapeutic class to be included on the preferred drug list;

(iii) Appropriate exclusions for medications, including atypical anti-psychotics, used for the treatment of serious mental illnesses such as bi-polar disorders, schizophrenia, and depression;

(iv) Appropriate exclusions for medications used for the treatment of brain disorders, cancer and HIV-related conditions;

(v) Appropriate exclusions for therapeutic classes in which there is only one drug in the therapeutic class or there is very low utilization, or for which it is not cost effective to include in the preferred drug list program;

(vi) Appropriate grandfather clauses when prior authorization would interfere with established complex drug regimens that have proven to be clinically effective;

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(vii) Other clinical criteria that may be included in the pharmacy program; and

(viii) Guidance and recommendations regarding the department's pharmacy programs.

C. In formulating its recommendations to the department, the committee shall not be deemed to be formulating regulations for the purposes of the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia).

D. Pursuant to 42 USC § 1396r-8(b)(3)(D), information disclosed to the department or to the committee by a manufacturer or wholesaler which discloses the identity of a specific manufacturer or wholesaler and the pricing information regarding the drugs by such manufacturer or wholesaler is confidential and shall not be subject to the disclosure requirements of the Virginia Freedom of Information Act (§ 2.2-3700 et seq. of the Code of Virginia).

E. Immunity. The members of the committee and the staff of the department and the contractor shall be immune, individually and jointly, from civil liability for any act, decision, or omission done or made in performance of their duties pursuant to this subsection while serving as a member of such board, committee, or staff provided that such act, decision, or omission is not done or made in bad faith or with malicious intent.

F. Pharmacy prior authorization program. Pursuant to § 1927 of the Act and 42 CFR 440.230, the department shall require the prior authorization of certain specified legend drugs. For those therapeutic classes of drugs subject to the preferred drug list program, drugs not included in the DMAS preferred drug list shall be subject to prior authorization. The department also may require prior authorization of other drugs only if recommended by the P&T Committee. Providers who are licensed to prescribe legend drugs shall be required to obtain prior authorization for all nonpreferred drugs or other drugs as recommended by the P&T Committee.

G. Prior authorization shall consist of prescription review by a licensed pharmacist or pharmacy technician to ensure that all predetermined clinically appropriate criteria, as established by the P&T Committee relative to each therapeutic class, have been met before the prescription may be dispensed. Prior authorization shall be obtained through a call center staffed with appropriate clinicians, or through written or electronic communications (e.g., faxes, mail). Responses by telephone or other telecommunications device within 24 hours of a request for prior authorization shall be provided. The dispensing of a 72-hour emergency supply of the prescribed drug shall be permitted and dispensing fees shall be paid to the pharmacy for such emergency supply.

H. The preferred drug list program shall include: (i) provisions for an expedited review process of denials of requested prior authorization by the department; (ii) consumer and provider education, (iii) training and information regarding the preferred drug list both prior to implementation as well as ongoing communications, to include computer and website access to information and multilingual material.

I. Appeals for denials of prior authorization shall be addressed pursuant to 12 VAC 30-110-10, Part I, Client Appeals.

J. Pharmacy contractor. The department may contract for pharmaceutical benefit management services to manage, implement and administer the Medicaid pharmacy benefits preferred drug list, as directed, authorized, and as may be amended from time to time, by DMAS.

1. The department, as the sole Title XIX authority for the Commonwealth, shall retain final administrative authority over all pharmacy services.

2. The department shall not offer or pay directly or indirectly any material inducement, bonus, or other financial incentive to a program contractor based on the denial or administrative delay of medically appropriate prescription drug therapy, or on the decreased use of a particular drug or class of drugs, or a reduction in the proportion of beneficiaries who receive prescription drug therapy under the Medicaid program. Bonuses shall not be based on the percentage of cost savings generated under the benefit management of services.

K. Supplemental rebates. The department shall have the authority to seek supplemental rebates from drug manufacturers. The contract regarding supplemental rebates shall exist between the manufacturer and the Commonwealth. Rebate agreements between the Commonwealth and a pharmaceutical manufacturer shall be separate from the federal rebates and in compliance with federal law, §§ 1927(a)(1) and 1927(a)(4) of the Social Security Act (Act). All rebates collected on behalf of the Commonwealth shall be collected for the sole benefit of the state share of costs. One hundred percent (100%) of the supplemental rebates collected on behalf of the state shall be remitted to the state. Supplemental drug rebates received by the Commonwealth in excess of those required under the national drug rebate agreement will be shared with the federal government on the same percentage basis as applied under the national drug rebate agreement.

L. Appeals. The department shall provide an expedient reconsideration process and initiate and fully participate in the DMAS' appeal process pursuant to 12 VAC 30-110, Part I, Client Appeals for providers and recipients.

M. Annual report. The department shall report to the Governor and the Chairmen of the House Appropriations and Senate Finance Committees on an annual basis.

/s/ Mark R. Warner
Governor

Date: November 20, 2003

VA.R. Doc. No. R04-55; Filed November 25, 2003, 3:45 p.m.

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Title of Regulation: 12 VAC 30-120. Waivered Services (amending 12 VAC 30-120-350).

Statutory Authority: §§ 32.1-324 and 32.1-325 of the Code of Virginia and Item 325 R of Chapter 1042 of the 2003 Acts of Assembly.

Effective Dates: December 4, 2003 through December 3, 2004.

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Preamble:

This regulatory action qualifies as an emergency pursuant to the authority of § 2.2-4011 of the Code of Virginia because it is responding to a mandate in the 2003 Virginia Appropriation Act (Item 325 R) that the Virginia MEDALLION programs conform to the federal Balanced Budget Act of 1997 (BBA) within 280 days from the date of the enactment of the Appropriation Act. This regulatory action is not otherwise exempt under the provisions of § 2.2-4006 of the Code of Virginia. This regulatory change is spurred by the BBA, found in the Code of Federal Regulations (CFR), specifically 42 CFR 438.700-704. While the BBA became law six years ago, the states are not required to comply with these requirements until August 2003. A final exempt regulation preceded the present emergency package, but this section was not included. The current regulatory change augments the provider sanctions section of 12 VAC 30-120-350 to include the stiffer penalties provided for under the BBA.

42 CFR 438.700-704 sets forth specific intermediate sanctions that may be imposed on PCPs for certain acts or omissions specified in the regulations. These sanctions include: additional civil money penalties with specific limits set out in 42 CFR 438.704, giving the PCP's enrollees the right to disenroll; suspension of the PCP's right to enroll new patients, and suspension of payments to the PCP. These new sanctions are in addition to those that may currently be imposed by the state.

12 VAC 30-120-350. PCP remedies for violation, breach, or nonperformance of provider agreement terms and addendum.

A. The sanctions, as described in § 1932(e)(1) of the Social Security Act (the Act) and listed in subsection B below, may be imposed by DMAS if the PCP:

- 1. Fails substantially to provide medically necessary services that the PCP is required to provide, under law or under its contract with DMAS, to an enrollee covered under the contract.*
- 2. Imposes, on enrollees, premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program.*
- 3. Acts to discriminate among enrollees on the basis of their health status or need for health care services.*
- 4. Misrepresents or falsifies information furnished to the Commonwealth.*
- 5. Misrepresents or falsifies information furnished to an enrollee, potential enrollee, or health care provider.*
- 6. Has distributed directly or indirectly, through any agent or independent contractor, marketing materials that have not*

been approved by DMAS or that contain false or materially misleading information.

7. Has violated any of the other applicable requirements of § 1932 or § 1905(t)(3) of the Act and any implementing regulations.

8. For those violations referred to in subsection (A)(7) above, DMAS may impose any of the sanctions listed in 42 CFR 438.702(a)(3)-(5).

B. Section 1932(e)(2) of the Act provides for the Commonwealth to impose the following civil money penalties and other sanctions:

1. A maximum of \$25,000 for each determination of failure to provide services; misrepresentations or false statements to enrollees, potential enrollees, or health care providers; or marketing violations.

2. A maximum of \$100,000 for each determination of discrimination or misrepresentation or false statements to the Commonwealth.

3. A maximum of \$15,000 for each recipient the Commonwealth determines was not enrolled because of a discriminatory practice (subject to the \$100,000 overall limit specified in (B)(2) above).

4. A maximum of \$25,000 or double the amount of the excess charges (whichever is greater) for charging premiums or charges in excess of the amounts permitted under the Medicaid program. DMAS shall deduct the excess amount charged from the penalty and return it to the affected enrollees.

~~*A. 5. Termination. Either the PCP or DMAS may terminate the PCP's enrollment in the MEDALLION program at any time if either party determines that the other party has failed to perform any of its functions or duties under the addendum to the provider agreement (hereafter referred to as the addendum) between the department and the PCP. In such event, the party exercising this option shall notify the other party in writing of the intent to terminate the addendum and shall give the other party 30 days to correct the identified violation, breach or nonperformance of the addendum. If such violation, breach or nonperformance of the addendum is not satisfactorily addressed within this time period, the exercising party must notify the other party in writing of its intent to terminate the addendum at least 60 days prior to the proposed termination date. The termination date shall always be the last day of the month in which the 60th day falls. The addendum may be terminated by DMAS sooner than the time periods for notice specified in this subsection if DMAS determines that a recipient's health or welfare is jeopardized by continued enrollment under the care of the PCP. After DMAS notifies a PCP that it intends to terminate the contract, DMAS will give the PCP's enrollees written notice of the state's intent to terminate the contract and will allow enrollees to disenroll immediately without cause. The state shall provide a pretermination hearing pursuant to 42 CFR 438.710.*~~

~~*B. 6. Suspension of new enrollment, including default enrollment.*~~

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4. a. Whenever DMAS determines that the PCP is out of compliance with the addendum, it may suspend the PCP's right to enroll new recipients. DMAS, when exercising this option, shall notify the PCP in writing of its intent to suspend new enrollment at least 30 days prior to the beginning of the suspension period. The suspension period may be for any length of time specified by DMAS, or may be indefinite. The suspension period may extend up to any expiration date of the addendum.

2. b. DMAS may also suspend new enrollment or disenroll recipients in anticipation of the PCP not being able to comply with federal or state laws at its current enrollment level. Such suspension shall not be subject to the 30-day notification requirement. DMAS may notify recipients of their PCP's noncompliance and provide an opportunity to enroll with another PCP.

7. Withholding of management or other payments and recovery of damage costs. DMAS may withhold portions of management or other fees or otherwise recover damages from the PCP as follows:

4. a. Whenever DMAS determines that the PCP has failed to perform an administrative function required under this contract, ~~the department~~ DMAS may withhold a portion of management or other fees to compensate for the damages which this failure has entailed. For the purposes of this section, "administrative function" is defined as any contract obligation other than the actual provision of contract services.

2. b. In any case under this contract where DMAS has the authority to withhold management or other fees, DMAS also shall have the authority to use all other legal processes for the recovery of damages.

8. Department-initiated disenrollment. DMAS may reduce the maximum enrollment level or number of current enrollees whenever it determines that the PCP has:

a. Failed to provide or arrange for the provision of one or more of the services required under the addendum to the provider agreement, or ~~that the PCP has~~

b. Failed to maintain or make available any records or reports required under the addendum which DMAS requires to determine whether the PCP is providing services as required. The PCP shall be given at least 30 days notice prior to DMAS taking any action set forth in this subsection.

9. Inappropriate service delivery. PCPs demonstrating a pattern of inappropriate provision of services may be subject to suspension of new enrollments, withholding, in full or in part, of management fees, addendum termination, or refusal to be offered the opportunity to participate as a PCP in a future time period.

/s/ Mark R. Warner
Governor

Date: December 2, 2003

VA.R. Doc. No. R04-58; Filed December 4, 2003, 4:17 p.m.

Title of Regulation: **12 VAC 30-120. Waivered Services (amending 12 VAC 30-120-370, 12 VAC 30-120-380 and 12 VAC 30-120-420).**

Statutory Authority: §§ 32.1-324 and 32.1-325 of the Code of Virginia and Item 325R of Chapter 1042 of the 2003 Acts of Assembly.

Effective Dates: December 15, 2003, through December 14, 2004.

Agency Contact: Patti Davidson, Division of Health Care Services, Department of Medical Assistance Services, 600 E. Broad Street, Suite 1300, Richmond, VA 23219, telephone (804) 786-8453, FAX (804) 786-1680, or e-mail pdavids2@dmass.state.va.us.

Preamble:

This action qualifies as an emergency regulation, pursuant to the authority of § 2.2-4011 of the Code of Virginia because it is responding to a mandate in the 2003 Virginia Appropriation Act (Item 325 R1 and R2) and is not otherwise exempt under the provisions of § 2.2-4006 of the Code of Virginia. A final exempt regulation, incorporating changes mandated by the Balanced Budget Act of 1997 (BBA) and its companion regulations, preceded the present emergency package and became effective August 13, 2003.

The revisions set forth in this regulatory package reflect certain programmatic changes made to the Medallion II Waiver, clarify certain existing provisions, and incorporate certain optional changes set forth in the BBA and corresponding regulations. Revisions include changes to the exemptions to enrollment to Medallion II (12 VAC 30-120-370) and modifications to the grievance and appeal process (12 VAC 30-120-420). 12 VAC 30-120-380 was also revised to be consistent with 42 CFR 438.108.

Substance:

Medallion II Enrollees (12 VAC 30-120-370) - DMAS is adding a section (12 VAC 30-120-370 B 14) that authorizes the agency to disenroll any client that engages in a pattern of noncompliance with Medallion II rules, guidelines and procedures. Before DMAS can disenroll a Medallion II recipient pursuant to this section, it must provide sufficient evidence of the client's noncompliance. DMAS must also document any efforts made to resolve the client's noncompliance before imposing disenrollment. The client may appeal DMAS' disenrollment decision.

The section governing disenrollment for good cause (12 VAC 30-120-370 H 2) was amended to clarify that a written response be provided to a good cause request in the timeframe set by DMAS and in compliance with 42 CFR 438.56.

MCO responsibilities (12 VAC 30-120-380 I) - This section was revised to conform this provision with 42 CFR 438.108, regarding cost sharing obligations that can be imposed by Medallion II MCOs.

Client Grievances (12 VAC 30-120-420) - The changes to this section specify that the enrollee must follow up an oral request

for an appeal with a written request within 10 business days (unless the request is for an expedited appeal). Although 438.402 b(3)(ii) requires that an oral request for appeal be followed up with a written request, it has provided the state with discretion in establishing the timeframe. The changes to this section also clarify who may follow up on the enrollee's behalf.

The requirement that MCO's provide DMAS with documentation of any written requests was deleted since each MCO submits a monthly appeal/grievance report that meets the Department's monitoring needs. The timeframe by which DMAS must issue standard appeal decisions was changed from 14 to 30 days.

12 VAC 30-120-370. Medallion II enrollees.

A. DMAS shall determine enrollment in Medallion II. Enrollment in Medallion II is not a guarantee of continuing eligibility for services and benefits under the Virginia Medical Assistance Services Program.

B. The following individuals shall be excluded from participating in Medallion II. Individuals not meeting the exclusion criteria must participate in the Medallion II program.

1. Individuals who are inpatients in state mental hospitals;
2. Individuals who are approved by DMAS as inpatients in long-stay hospitals, nursing facilities, or intermediate care facilities for the mentally retarded;
3. Individuals who are placed on spend-down;
4. Individuals who are participating in federal waiver programs for home-based and community-based Medicaid coverage;
5. Individuals who are participating in foster care or subsidized adoption programs;
6. Individuals who are enrolled in DMAS authorized residential treatment or treatment foster care programs;
7. Newly eligible individuals who are in the third trimester of pregnancy and who request exclusion within a department-specified timeframe of the effective date of their MCO enrollment. Exclusion may be granted only if the member's obstetrical provider (physician or hospital) does not participate with any of the state-contracted MCOs. Exclusion requests made during the third trimester may be made by the recipient, MCO, or provider. DMAS shall determine if the request meets the criteria for exclusion. Following the end of the pregnancy, these individuals shall be required to enroll to the extent they remain eligible for Medicaid;
8. Individuals, other than students, who permanently live outside their area of residence for greater than 60 consecutive days except those individuals placed there for medically necessary services funded by the MCO;
9. Individuals who receive hospice services in accordance with DMAS criteria;
10. Individuals with Medicare coverage;

11. Individuals requesting exclusion who are inpatients in hospitals, other than those listed in subdivisions 1 and 2 of this subsection, at the scheduled time of enrollment or who are scheduled for inpatient hospital stay or surgery within 30 calendar days of the enrollment effective date. The exclusion shall remain effective until the first day of the month following discharge;

12. Individuals who have been preassigned to an MCO but have not yet been enrolled, who have been diagnosed with a terminal condition and who have a life expectancy of six months or less, if they request exclusion. The client's physician must certify the life expectancy; and

13. Certain individuals between birth and age three certified by the Department of Mental Health, Mental Retardation and Substance Abuse Services as eligible for services pursuant to Part C of the Individuals with Disabilities Education Act (20 USC § 1471 et seq.) who are granted an exception by DMAS to the mandatory Medallion II enrollment.

DMAS reserves the right to restrict from participation in the Medallion II managed care program any recipient who has been consistently noncompliant with the policies, procedures, and philosophies of managed care, or is threatening to providers, MCO(s), or DMAS. There must be sufficient documentation from various providers, the MCO(s), and DMAS of these noncompliance issues and any attempts at resolution. Recipients excluded from Medallion II through this provision may appeal the decision to DMAS.

C. Medallion II managed care plans shall be offered to recipients, and recipients shall be enrolled in those plans, exclusively through an independent enrollment broker under contract to DMAS.

D. Clients shall be enrolled as follows:

1. All eligible persons, except those meeting one of the exclusions of subsection B of this section, shall be enrolled in Medallion II.
2. Clients shall receive a Medicaid card from DMAS during the interim period, and shall be provided authorized medical care in accordance with DMAS' procedures, after eligibility has been determined to exist.
3. Once individuals are enrolled in Medicaid, they will receive a letter indicating that they may select one of the contracted MCOs. These letters shall indicate a preassigned MCO, determined as provided in subsection E of this section, in which the client will be enrolled if he does not make a selection within a period specified by DMAS of not less than 30 days.
4. A child born to a woman enrolled with an MCO will be enrolled with the MCO from birth until the last day of the third month including the month of birth, unless otherwise specified by the Enrollment Broker. For instance, a child born during the month of February will be automatically enrolled until April 30. By the end of that third month, the child will be disenrolled unless the Enrollment Broker specifies continued enrollment. If the child remains an inpatient in a hospital at the end of that third month, the child shall automatically remain enrolled until the last day of

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the month of discharge, unless this child's parent requests disenrollment.

5. Individuals who lose then regain eligibility for Medallion II within 60 days will be reenrolled into their previous MCO without going through preassignment and selection.

E. Clients who do not select an MCO as described in subdivision D 3 of this section shall be assigned to an MCO as follows:

1. Clients are assigned through system algorithm based upon the client's history with a contracted MCO.
2. Clients not assigned pursuant to subdivision 1 of this subsection shall be assigned to the MCO of another family member, if applicable.
3. All other clients shall be assigned to an MCO on a basis of approximately equal number by MCO in each locality.
4. In areas where there is only one contracted MCO, recipients have a choice of enrolling with the contracted MCO or the PCCM program. All eligible recipients in areas where one contracted MCO exists, however, are automatically assigned to the contracted MCO. Individuals are allowed 90 days after the effective date of new or initial enrollment to change from either the contracted MCO to the PCCM program or vice versa.

F. Following their initial enrollment into an MCO or PCCM program, recipients shall be restricted to the MCO or PCCM program until the next open enrollment period, unless appropriately disenrolled or excluded by the department.

1. During the first 90 calendar days of enrollment in a new or initial MCO, a client may disenroll from that MCO to enroll into another MCO or into PCCM, if applicable, for any reason. Such disenrollment shall be effective no later than the first day of the second month after the month in which the client requests disenrollment.
2. During the remainder of the enrollment period, the client may only disenroll from one MCO into another MCO or PCCM, if applicable, upon determination by DMAS that good cause exists as determined under subsection H of this section.

G. The department shall conduct an annual open enrollment for all Medallion II participants, including in areas where there is only one contracted MCO. The open enrollment period shall be the 60 calendar days before the end of the enrollment period. Prior to the open enrollment period, DMAS will inform the recipient of the opportunity to remain with the current MCO or change to another MCO, without cause, for the following year. In areas with only one contracted MCO, recipients will be given the opportunity to select either the MCO or the PCCM program. Enrollment selections will be effective on the first of the next month following the open enrollment period. Recipients who do not make a choice during the open enrollment period will remain with their current MCO selection.

H. Disenrollment for good cause may be requested at any time.

1. After the first 90 days of enrollment in an MCO, clients must request disenrollment from DMAS based on good

cause. The request may be made orally or in writing to DMAS and must cite the reasons why the client wishes to disenroll. Good cause for disenrollment shall include the following:

- a. A recipient's desire to seek services from a federally qualified health center which is not under contract with the recipient's current MCO, and the recipient (i) requests a change to another MCO that subcontracts with the desired federally qualified health center or (ii) requests a change to the PCCM, if the federally qualified health center is contracting directly with DMAS as a PCCM;
- b. Performance or nonperformance of service to the recipient by an MCO or one or more of its providers which is deemed by the department's external quality review organizations to be below the generally accepted community practice of health care. This may include poor quality care;
- c. Lack of access to necessary specialty services covered under the State Plan or lack of access to providers experienced in dealing with the enrollee's health care needs.
- d. A client has a combination of complex medical factors that, in the sole discretion of DMAS, would be better served under another contracted MCO or PCCM program, if applicable, or provider;
- e. The enrollee moves out of the MCO's service area;
- f. The MCO does not, because of moral or religious objections, cover the service the enrollee seeks;
- g. The enrollee needs related services to be performed at the same time; not all related services are available within the network, and the enrollee's primary care provider or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk; or
- h. Other reasons as determined by DMAS through written policy directives.

2. DMAS shall determine whether good cause exists for disenrollment. *Written responses shall be provided within a timeframe set by department policy; however, the effective date of an approved disenrollment shall be no later than the first day of the second month following the month in which the enrollee files the request, in compliance with 42 CFR 438.56.*

3. Good cause for disenrollment shall be deemed to exist and the disenrollment shall be granted if DMAS fails to take final action on a valid request prior to the first day of the second month after the request.

4. The DMAS determination concerning good cause for disenrollment may be appealed by the client in accordance with the department's client appeals process at 12 VAC 30-110-10 through 12 VAC 30-110-380.

5. The current MCO shall provide, within two working days of a request from DMAS, information necessary to determine good cause.

12 VAC 30-120-380. Medallion II MCO responsibilities.

A. The MCO shall provide, at a minimum, all medically necessary covered services provided under the State Plan for Medical Assistance and further defined by written DMAS regulations, policies and instructions, except as otherwise modified or excluded in this part.

Nonemergency services provided by hospital emergency departments shall be covered by MCOs in accordance with rates negotiated between the MCOs and the emergency departments.

B. Services that shall be provided outside the MCO network, and reimbursed by DMAS shall include, but are not limited to, those services defined by the contract between DMAS and the MCO. Services reimbursed by DMAS include school-based services and community mental health services (rehabilitative, targeted case management and substance abuse services). The MCOs shall pay for emergency services and family planning services and supplies whether they are provided inside or outside the MCO network.

C. The MCOs shall report data to DMAS under the contract requirements, which may include data reports, report cards for clients, and ad hoc quality studies performed by the MCO or third parties.

D. Documentation requirements.

1. The MCO shall maintain such records as may be required by federal and state law and regulation and by DMAS policy. The MCO shall furnish such required information to DMAS, the Attorney General of Virginia or his authorized representatives, or the State Medicaid Fraud Control Unit on request and in the form requested.

2. Each MCO shall have written policies regarding enrollee rights and must comply with any applicable federal and state laws that pertain to enrollee rights and ensure that its staff and affiliated providers take those rights into account when furnishing services to enrollees in accordance with 42 CFR 438.100.

E. The MCO shall ensure that the health care provided to its clients meets all applicable federal and state mandates, community standards for quality, and standards developed pursuant to the DMAS managed care quality program.

F. The MCOs shall promptly provide or arrange for the provision of all required services as specified in the contract between the state and the contractor. Medical evaluations shall be available within 48 hours for urgent care and within 30 calendar days for routine care. On-call clinicians shall be available 24 hours per day, seven days per week.

G. The MCOs must meet standards specified by DMAS for sufficiency of provider networks as specified in the contract between the state and the contractor.

H. Each MCO and its subcontractors shall have in place, and follow, written policies and procedures for processing requests for initial and continuing authorizations of service. Each MCO and its subcontractors shall ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be

made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease. Each MCO and its subcontractors shall have in effect mechanisms to ensure consistent application of review criteria for authorization decisions and consult with the requesting provider when appropriate.

I. ~~The~~ *In accordance with 42 CFR 447.50 through 42 CFR 447.60*, MCOs shall not charge copayments to any ~~categorically needy~~ *impose cost sharing obligations on enrollees except as set forth in 12 VAC 30-20-150 and 12 VAC 30-20-160.*

J. An MCO may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his patient in accordance with 42 CFR 438.102.

K. An MCO that would otherwise be required to provide, reimburse for, or provide coverage of, a counseling or referral service is not required to do so if the MCO objects to the service on moral or religious grounds and furnishes information about the service it does not cover in accordance with 42 CFR 438.102.

12 VAC 30-120-420. Client grievances and appeals.

A. The MCOs shall, whenever a client's request for covered services is reduced, denied or terminated, or payment for services is denied, provide a written notice in accordance with the notice provisions specified in 42 CFR 438.404 and 42 CFR 438.210(c), as defined by the contract between DMAS and the MCO, and any other statutory or regulatory requirements.

B. MCOs shall, at the initiation of either new client enrollment or new provider/subcontractor contracts, or at the request of the enrollee, provide to every enrollee the information described in 42 CFR 438.10(g) concerning grievance/appeal rights and procedures.

C. Disputes between the MCO and the client concerning any aspect of service delivery, including medical necessity and specialist referral, shall be resolved through a verbal or written grievance/appeals process operated by the MCO or through the DMAS appeals process. A provider who has the enrollee's written consent may act on behalf of an enrollee in the MCO grievance/appeals or the DMAS appeals process.

1. The enrollee, provider, or representative acting on behalf of the enrollee with the enrollee's written consent, may file an oral or written grievance or appeal with the MCO. The MCO must accept grievances or appeals submitted within 30 days from the date of the notice of adverse action. Oral requests for appeals must be followed up in writing *within 10 business days* by the enrollee, provider, or his representative *acting on behalf of the enrollee with the enrollee's consent*, unless the request is for an expedited appeal. The enrollee may also file a written request for a standard or expedited appeal with the DMAS Appeals Division within 30 days of the client's receipt of the notice of adverse action, in accordance with 42 CFR Part 431, Subpart E and 12 VAC 30-110.

2. In compliance with 14 VAC 5-210-70 H 4, pending resolution of a grievance or appeal filed by a client or his

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representative (including a provider acting on behalf of the client), coverage shall not be terminated for the client for any reason which is the subject of the complaint. In addition, the MCO shall not terminate or reduce services as specified in 12 VAC 30-110-100.

3. The MCO shall ensure that the individuals who make decisions on MCO grievances and appeals were not involved in any previous level of review or decision making, and where the reason for the grievance or appeal involves clinical issues, relates to a denial or a request for an expedited appeal, or where the appeal is based on a lack of medical necessity, shall ensure that the decision makers are health care professionals with the appropriate clinical expertise in treating the enrollee's condition or disease.

D. The MCO shall develop written materials describing the grievance/appeals system and its procedures and operation.

E. The MCO shall maintain a recordkeeping and tracking system for complaints, grievances, and appeals that includes a copy of the original complaint, grievance, or appeal; the decision; and the nature of the decision. This system shall distinguish Medicaid from commercial enrollees, if the MCO does not have a separate system for Medicaid enrollees.

F. At the time of enrollment and at the time of any adverse actions, the MCO shall notify the client, in writing, that:

1. Medical necessity, specialist referral or other service delivery issues may be resolved through a system of grievances and appeals, within the MCO or through the DMAS client appeals process;
2. Clients have the right to appeal directly to DMAS; and
3. The MCO shall promptly provide grievance or appeal forms, reasonable assistance and written procedures to clients who wish to register written grievances or appeals.

G. The MCO shall, within two days of receipt of any written request for a grievance or appeal, provide DMAS with a copy of the request.

H. The MCO shall issue grievance/appeal decisions as defined by the contract between DMAS and the MCO. Oral grievance decisions are not required to be in writing.

I. The MCO shall issue standard appeal decisions within 44 30 days from the date of initial receipt of the appeal in accordance with 42 CFR 438.408 and as defined by the contract between DMAS and the MCO. The appeal decision shall be required to be in writing and shall include but is not limited to:

1. The decision reached, the results and the date of the decision reached by the MCO;
2. The reasons for the decision;
3. The policies or procedures which provide the basis for the decision;
4. A clear explanation of further appeal rights and a timeframe for filing an appeal; and
5. For appeals that involve the termination, suspension, or reduction of a previously authorized course of treatment, the

right to continue to receive benefits in accordance with 42 CFR 438.420 pending a hearing, and how to request continuation of benefits.

J. The MCO shall provide DMAS with a copy of its grievance or appeal decision concurrently with the provision of the decision to the client.

K. An expedited appeal decision shall be issued as expeditiously as the enrollee's condition requires and within three business days in cases of medical emergencies in which delay could result in death or serious injury to a client. Extensions to these timeframes shall be allowed in accordance with 42 CFR 438.408 and as defined by the contract between DMAS and the MCO. Written confirmation of the decision shall promptly follow the verbal notice of the expedited decision.

L. Any appeal decision issued by the MCO may be appealed by the client to DMAS in accordance with the department's Client Appeals regulations at 12 VAC 30-110-10 through 12 VAC 30-110-380. DMAS shall conduct an evidentiary hearing in accordance with the Client Appeals regulations at 12 VAC 30-110-10 through 12 VAC 30-110-380 and shall not base any appealed decision on the record established by any appeal decision of the MCO. The MCO shall comply with the DMAS appeal decision. The DMAS decision in these matters shall be final and shall not be subject to appeal by the MCO.

M. The MCO shall provide information necessary for any DMAS appeal within timeframes established by DMAS.

/s/ Mark R. Warner
Governor

Date: December 2, 2003

VA.R. Doc. No. R04-57; Filed December 4, 2003, 4:21 p.m.

GENERAL NOTICES/ERRATA

DEPARTMENT OF ENVIRONMENTAL QUALITY

Data Concerning the Presence of Toxic Contaminants in Fish Tissue and Sediments

Pursuant to § 62.1-44.19:6 A 3 of the Code of Virginia, the Virginia Department of Environmental Quality (DEQ) is giving notice that new data concerning the presence of toxic contaminants in fish tissue and sediments are available for the fish and sediment monitoring performed by DEQ in the calendar year 2002. The routine and special fish and sediment monitoring in 2002 was performed at selected sites in the river basins of the James River, New River, Roanoke River, Dan River, Clinch River, Holston River, Yadkin River, Tennessee-Big Sandy River basin, Chowan River and Albemarle Sound basins, and at several sites in the small coastal tributaries to Chesapeake Bay. Data for all these monitoring studies as well as data from previous years are all available on the DEQ website at www.deq.state.va.us/fishtissue/fishtissue.html. For additional information contact Alex Barron directly at (804) 698-4119, or e-mail ambarron@deq.state.va.us, or call toll free 1-800-592-5482 and request Mr. Barron.

Total Maximum Daily Load (TMDL) for Toms Brook

The Department of Environmental Quality (DEQ) seeks written and oral comments from interested persons on the development of a Total Maximum Daily Load (TMDL) for Toms Brook. This stream is listed on the 1998 303(d) TMDL Priority List and Report as impaired due to violations of the state's general standard for aquatic life. The Toms Brook stream segment is located in Shenandoah County. It is 7.18 miles in length and begins at the headwaters and continues to the confluence with the North Fork of the Shenandoah River.

Section 303(d) of the Clean Water Act and § 62.1-44.19:7 C of the Code of Virginia require DEQ to develop TMDLs for pollutants responsible for each impaired water contained in Virginia's 303(d) TMDL Priority List and Report.

The final public meeting on the development of the Toms Brook TMDL will be held on Tuesday, January 13, 2004, 7 p.m. at the Toms Brook Volunteer Fire Department which is located at 3342 Main Street in Toms Brook, Virginia.

A copy of the draft TMDL report addressing the Toms Brook impairment will be available for review by January 9, 2004, on the DEQ website at <http://www.deq.state.va.us/tmdl/tmdlrpts.html>. The public comment period for the draft report and the meeting will end on February 12, 2004. Written comments should include the name, address, and telephone number of the person submitting the comments and should be sent to Robert Brent, Department of Environmental Quality, 4411 Early Road, P.O. Box 3000, Harrisonburg, VA 22801, telephone (540) 574-7848, FAX (540) 574-7878, or e-mail rnbrent@deq.state.va.us.

STATE WATER CONTROL BOARD

Proposed Consent Special Order Town of Rocky Mount and the County of Franklin

The State Water Control Board (SWCB) proposes to issue a Consent Special Order to the Town of Rocky Mount and the County of Franklin regarding compliance with the Virginia Water Protection Permit Program Regulation, 9 VAC 25-210, at the Trinity Packaging Site in Rocky Mount. On behalf of the SWCB, the department will consider written comments relating to this order for 30 days after the date of publication of this notice. Comments should be addressed to Robert Steele, Department of Environmental Quality, West Central Regional Office, 3019 Peters Creek Road, NW, Roanoke, VA 24019.

The final order may be examined at the department during regular business hours. It may also be viewed or downloaded from the Department of Environmental Quality homepage at www.deq.state.va.us/info. Copies are available from Mr. Steele at the address above or by calling him at (540) 562-6777.

Consent Special Order - Town of Victoria

The Department of Environmental Quality, on behalf of the State Water Control Board, and the Town of Victoria have agreed to a Consent Special Order in settlement of a civil enforcement action under the Virginia State Water Control Law permit regulation 9 VAC 25-31, regarding the town's west wastewater treatment plant and conveyance system. The department will consider written comments relating to this order for 30 days, until 5 p.m. on January 28, 2004. Comments must include name, address, and telephone number and can be e-mailed to hfwaggoner@deq.state.va.us or mailed to Harry F. Waggoner, Department of Environmental Quality, South Central Regional Office, 7705 Timberlake Road, Lynchburg, VA 24502.

The order is available at www.deq.state.va.us/enforcement/notices.html and at the above office during regular business hours. You may request copies from Mr. Waggoner by calling him at telephone (434) 582-5120.

VIRGINIA CODE COMMISSION

Notice to State Agencies

Mailing Address: Virginia Code Commission, 910 Capitol Street, General Assembly Building, 2nd Floor, Richmond, VA 23219, FAX (804) 692-0625.

Forms for Filing Material for Publication in the *Virginia Register of Regulations*

All agencies are required to use the appropriate forms when furnishing material for publication in the Virginia Register of Regulations. The forms may be obtained from: Virginia Code Commission, 910 Capitol Street, General Assembly Building, 2nd Floor, Richmond, VA 23219, telephone (804) 786-3591.

General Notices/Errata

Internet: Forms and other Virginia Register resources may be printed or downloaded from the Virginia Register web page: <http://register.state.va.us>.

FORMS:

NOTICE of INTENDED REGULATORY ACTION-RR01
NOTICE of COMMENT PERIOD-RR02
PROPOSED (Transmittal Sheet)-RR03
FINAL (Transmittal Sheet)-RR04
EMERGENCY (Transmittal Sheet)-RR05
NOTICE of MEETING-RR06
AGENCY RESPONSE TO LEGISLATIVE OBJECTIONS-RR08
RESPONSE TO PETITION FOR RULEMAKING-RR13
FAST-TRACK RULEMAKING ACTION-RR14

ERRATA

CRIMINAL JUSTICE SERVICES BOARD

Title of Regulation: **6 VAC 20-190. Regulations for Breath Alcohol Testing.**

Publication: 20:4 VA.R. 346-348 November 3, 2003.

Correction to Final Regulation:

Page 348, 6 VAC 20-190-160 B, line 5 after "file for" insert "at least three years."

STATE CORPORATION COMMISSION

Title of Regulation: **14 VAC 5-310. Rules Governing Actuarial Opinions and Memoranda.**

Publication: 20:5 VA.R. 468-482 November 17, 2003.

Correction to Final Regulation:

Page 478, column 1 in 14 VAC 5-310-80 B 3 at top of page, after "reasonableness.," strike "OR"

CALENDAR OF EVENTS

Symbol Key

- † Indicates entries since last publication of the *Virginia Register*
♿ Location accessible to persons with disabilities
☎ Teletype (TTY)/Voice Designation

NOTICE

Only those meetings which are filed with the Registrar of Regulations by the filing deadline noted at the beginning of this publication are listed. Since some meetings are called on short notice, please be aware that this listing of meetings may be incomplete. Also, all meetings are subject to cancellation and the *Virginia Register* deadline may preclude a notice of such cancellation. If you are unable to find a meeting notice for an organization in which you are interested, please check the Commonwealth Calendar at www.vipnet.org or contact the organization directly.

For additional information on open meetings and public hearings held by the standing committees of the legislature during the interim, please call Legislative Information at (804) 698-1500 or Senate Information and Constituent Services at (804) 698-7410 or (804) 698-7419/TTY☎, or visit the General Assembly web site's Legislative Information System (<http://leg1.state.va.us/lis.htm>) and select "Meetings."

VIRGINIA CODE COMMISSION

EXECUTIVE

BOARD OF ACCOUNTANCY

January 6, 2004 - 10 a.m. -- Open Meeting
Holiday Inn-Richmond, 6531 West Broad Street, Richmond, Virginia.♿ (Interpreter for the deaf provided upon request)

A meeting to discuss regulatory review and other matters requiring the board's attention. A public comment period will be held at the beginning of the meeting. All meetings are subject to cancellation. The time of the meeting is subject to change. Any person desiring to attend the meeting and requiring special accommodations or interpreter services should contact the board at least 10 days prior to the meeting so suitable arrangements can be made. The board fully complies with the American with Disabilities Act.

Contact: Nancy Taylor Feldman, Executive Director, Board of Accountancy, 3600 W. Broad St., Suite 696, Richmond, VA 23230, telephone (804) 367-8505, FAX (804) 367-2174, (804) 367-9753/TTY☎, e-mail boa@boa.state.va.us.

February 6, 2004 - 10 a.m. -- Open Meeting
Holiday Inn-Richmond, 6531 West Broad Street, Richmond, Virginia.♿ (Interpreter for the deaf provided upon request)

A meeting to discuss general business matters including complaint cases. A public comment period will be held at the beginning of the meeting. All meetings are subject to cancellation. The time of the meeting is subject to change. Any person desiring to attend the meeting and requiring special accommodations or interpreter services should contact the board at least 10 days prior to the meeting so suitable arrangements can be made. The board fully complies with the American with Disabilities Act.

Contact: Nancy Taylor Feldman, Executive Director, Board of Accountancy, 3600 W. Broad St., Suite 696, Richmond, VA 23230, telephone (804) 367-8505, FAX (804) 367-2174, (804) 367-9753/TTY☎, e-mail boa@boa.state.va.us.

DEPARTMENT OF AGRICULTURE AND CONSUMER SERVICES

Virginia Horse Industry Board

† **February 4, 2004 - 10 a.m.** -- Open Meeting
Virginia Thoroughbred Association, 38-B Garrett Street, Warrenton, Virginia.♿

The board will review the minutes of the last meeting, its current financial statement, and ongoing projects for 2004. The board will also discuss the grant guidelines. The board will entertain public comment at the conclusion of all other business for a period not to exceed 30 minutes. Any person who needs any accommodation in order to participate at the meeting should contact the person identified in this notice at least five days before the meeting date, so that suitable arrangements can be made.

Contact: Andrea S. Heid, Equine Marketing Specialist/Program Manager, Department of Agriculture and Consumer Services, 1100 Bank St., 9th Floor, Richmond, VA 23219, telephone (804) 786-5842, FAX (804) 786-3122.

Virginia Irish Potato Board

January 12, 2004 - 7 p.m. -- Open Meeting
Eastern Shore Agricultural Research and Extension Center, Research Drive, Painter, Virginia.♿

A meeting to read and approve the minutes of the last meeting. In addition, the board will review its financial statement and discuss promotion, research, and education programs that may benefit the Irish potato industry. The board will review the annual budget and review and evaluate grant proposals for fiscal year 2004. The board will entertain public comment at the conclusion of all other business for a period not to exceed 30 minutes. Any person who needs any accommodation in order to participate at the meeting should contact the person identified in this notice at least five days before the meeting date so that suitable arrangements can be made.

Calendar of Events

Contact: Butch Nottingham, Program Manager, Department of Agriculture and Consumer Services, P.O. Box 26, Onley, VA 23418, telephone (757) 787-5867, FAX (757) 787-5973.

Virginia Sheep Industry Board

† **January 9, 2004 - 11 a.m.** -- Open Meeting
Sheraton Inn, 1400 East Market Street, Harrisonburg, Virginia
♿

The board will approve the minutes of the February 26, 2003, meeting and hear reports on the following agenda items: board's financial report, USDA Wildlife Services, Virginia Food Festival, Virginia Junior Sheep Breeders, Scott County Fair, Sheep Fair, and the Virginia Tech Farm and Family Showcase. The board will entertain public comment at the conclusion of all other business for a period not to exceed 30 minutes. Any person who needs any accommodation in order to participate at the meeting should contact the person identified in this notice at least one day before the meeting date so that suitable arrangements can be made.

Contact: Michael Carpenter, Program Director, Department of Agriculture and Consumer Services, 116 Reservoir St., Harrisonburg, VA 22801, telephone (540) 434-0779, FAX (540) 434-5607.

ALZHEIMER'S DISEASE AND RELATED DISORDERS COMMISSION

† **March 23, 2004 - 10 a.m.** -- Open Meeting
Virginia Department for the Aging, 1600 Forest Avenue, Suite 102, Richmond, Virginia. ♿ (Interpreter for the deaf provided upon request)

A business meeting.

Contact: Janet L. Honeycutt, Director of Grant Operations, Department for the Aging, 1600 Forest Ave., Suite. 102, Richmond, VA 23229, telephone (804) 662-9333, FAX (804) 662-9354, toll-free (800) 554-3402, (804) 662-9333/TTY ♿, e-mail jlhoneycutt@vdh.state.va.us.

ART AND ARCHITECTURAL REVIEW BOARD

January 9, 2004 - 10 a.m. -- Open Meeting
† **February 6, 2004 - 10 a.m.** -- Open Meeting
† **March 5, 2004 - 10 a.m.** -- Open Meeting
Science Museum of Virginia, 2500 West Broad Street, Richmond, Virginia. ♿

A monthly meeting to review projects submitted by state agencies.

Contact: Richard L. Ford, AIA Chairman, 101 Shockoe Slip, 3rd Floor, Richmond, VA 23219, telephone (804) 648-5040, FAX (804) 225-0329, toll free (804) 786-6152, or e-mail rford@comarchs.com.

VIRGINIA BOARD FOR ASBESTOS, LEAD, AND HOME INSPECTORS

January 7, 2004 - 9 a.m. -- Open Meeting
† **January 8, 2004 - 9 a.m.** -- Open Meeting
Department of Professional and Occupation Regulation, 3600 West Broad Street, 4th Floor, Room 453, Richmond, Virginia. ♿

A meeting to conduct an informal fact-finding conference.

Contact: David Dick, Assistant Director, Virginia Board for Asbestos, Lead, and Home Inspectors, 3600 W. Broad St., 4th Floor, Room 453, Richmond, VA 23230, telephone (804) 367-8595, FAX (804) 367-2475, (804) 367-9753/TTY ♿, e-mail asbestos@dpor.state.va.us.

February 18, 2004 - 9 a.m. -- Open Meeting
Department of Professional and Occupation Regulation, 3600 West Broad Street, Richmond, Virginia. ♿

A meeting to conduct board business.

Contact: David Dick, Executive Director, Virginia Board for Asbestos, Lead, and Home Inspectors, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-8507, FAX (804) 367-6128, (804) 367-9753/TTY ♿, e-mail asbestos@dpor.state.va.us.

COMPREHENSIVE SERVICES FOR AT-RISK YOUTH AND FAMILIES

State Executive Council

December 31, 2003 - 9 a.m. -- Open Meeting
Department of Social Services, 730 East Broad Street, Lower Level Room 3, Richmond, Virginia. ♿

A monthly council meeting. For traveling directions, please call (804) 692-1100.

Contact: Alan G. Saunders, Director, Office of Comprehensive Services, 1604 Santa Rosa Rd., Richmond, VA 23229, telephone (804) 662-9815, FAX (804) 662-9831, e-mail ags992@central.dss.state.va.us.

BOARD OF AUDIOLOGY AND SPEECH-LANGUAGE PATHOLOGY

February 19, 2004 - 9:30 a.m. -- Open Meeting
Department of Health Professions, 6603 West Broad Street, 5th Floor, Richmond, Virginia. ♿ (Interpreter for the deaf provided upon request)

A quarterly business meeting to include regulatory and disciplinary matters as may be presented on the agenda. Public comment will be received at the beginning of the meeting.

Contact: Elizabeth Young, Executive Director, Board of Audiology and Speech-Language Pathology, Alcoa Building, 6603 W. Broad St., 5th Floor, Richmond, VA 23230-1712, telephone (804) 662-9111, FAX (804) 662-9523, (804) 662-7197/TTY ♿, e-mail elizabeth.young@dhp.state.va.us.

BOARD FOR BARBERS AND COSMETOLOGY

January 12, 2004 - 9 a.m. -- Open Meeting

Department of Professional and Occupational Regulation,
3600 West Broad Street, 4th Floor, Room 453, Richmond,
Virginia. 

An meeting to conduct an informal fact-finding conference.

Contact: William H. Ferguson, II, Assistant Director, Board
for Barbers and Cosmetology, 3600 W. Broad St., Richmond,
VA 23230, telephone (804) 367-8575, FAX (804) 367-2474,
(804) 367-9753/TTY , e-mail
barbercosmo@dpor.state.va.us.

March 15, 2004 - 9 a.m. -- Open Meeting

Department of Professional and Occupational Regulation,
3600 West Broad Street, Richmond, Virginia. 

A general business meeting including consideration of
regulatory issues as may be presented on the agenda. The
meeting is open to the public; however, a portion of the
board's business may be discussed in closed session.
Public comment will be heard at the beginning of the
meeting. Persons desiring to participate in the meeting and
requiring special accommodations or interpreter services
should contact the department at least 10 days prior to the
meeting so that suitable arrangements can be made. The
department fully complies with the Americans with
Disabilities Act.

Contact: William H. Ferguson, II, Executive Director, Board
for Barbers and Cosmetology, 3600 W. Broad St., Richmond,
VA 23230-4917, telephone (804) 367-8590, FAX (804) 367-
6295, (804) 367-9753/TTY , e-mail
barbercosmo@dpor.state.va.us.

CEMETERY BOARD

January 21, 2004 - 9 a.m. -- Open Meeting

Department of Professional and Occupational Regulation,
3600 West Broad Street, 4th Floor, Room 453, Richmond,
Virginia. 

A meeting to conduct an informal fact-finding conference.

Contact: Karen W. O'Neal, Regulatory Programs
Coordinator, Department of Professional and Occupational
Regulation, 3600 W. Broad St., Richmond, VA 23230,
telephone (804) 367-8537, FAX (804) 367-2475, (804) 367-
9753/TTY , e-mail oneal@dpor.state.va.us.

CHILD DAY-CARE COUNCIL

January 2, 2004 - Public comments may be submitted until
this date.

Notice is hereby given in accordance with § 2.2-4007 of the
Code of Virginia that the Child Day-Care Council intends to
amend regulations entitled **22 VAC 15-30, Standards for
Licensed Child Day Centers**. The purpose of the proposed
action is to provide more protection for children in care, be
less intrusive and burdensome for providers, and clarify the
language. Changes were made throughout the regulation as

appropriate. Topics covered by the regulation include
administration, staff qualifications and training, physical
plant, staffing and supervision, programs, special care
provisions and emergencies, and special services.

Statutory Authority: §§ 63.2-1734 and 63.2-1735 of the Code
of Virginia.

Public comments may be submitted until January 2, 2004, to
Gail Johnson, Chair, Child Day-Care Council, 730 East Broad
Street, 7th Floor, Richmond, VA 23219.

Contact: Wenda Singer, Program Development Consultant,
Department of Social Services, 730 E. Broad St., Richmond,
VA 23219, telephone (804) 692-2201, FAX (804) 692-2370 or
e-mail wxs2@dss.state.va.us.

* * * * *

January 2, 2004 - Public comments may be submitted until
this date.

Notice is hereby given in accordance with § 2.2-4007 of the
Code of Virginia that the Child Day-Care Council intends to
repeal regulations entitled **22 VAC 15-50, Regulation for
Criminal Record Checks for Child Welfare Agencies**,
and adopt regulations entitled **22 VAC 15-51, Background
Checks for Licensed Child Day Centers**. The purpose of
the proposed action is to repeal the current regulation for
criminal background checks in order to promulgate a new
regulation that establishes background checks for licensed
child care centers in compliance with the Code of Virginia. A
background check is a sworn statement or affirmation, a
criminal history record check, and a child protective services
central registry check.

Statutory Authority: §§ 63.2-1734 and 63.2-1735 of the Code
of Virginia.

Public comments may be submitted until January 2, 2004.

Contact: Wenda Singer, Program Development Consultant,
Department of Social Services, 730 E. Broad St., Richmond,
VA 23219, telephone (804) 692-2201, FAX (804) 692-2370 or
e-mail wxs2@dss.state.va.us.

STATE BOARD FOR COMMUNITY COLLEGES

January 21, 2004 - 1:30 p.m. -- Open Meeting

† **March 17, 2004 - 1:30 p.m.** -- Open Meeting

James Monroe Building, 101 North 14th Street, Godwin-
Hamel Board Room, 15th Floor, Richmond, Virginia. 
(Interpreter for the deaf provided upon request)

Committees will meet as follows: Academic and Student
Affairs, Audit, and Budget and Finance will meet at 1:30
p.m.; Facilities and Personnel Committees will meet at
3 p.m.

Contact: D. Susan Hayden, Director of Public Affairs, State
Board for Community Colleges, 101 N. 14th St., 15th Floor,
Richmond, VA 23219, telephone (804) 819-4961, FAX (804)
819-4768, (804) 371-8504/TTY 

January 22, 2004 - 8:30 a.m. -- Open Meeting

† **March 18, 2004 - 8:30 a.m.** -- Open Meeting

Calendar of Events

James Monroe Building, 101 North 14th Street, Godwin-Hamel Board Room, 15th Floor, Richmond, Virginia.  (Interpreter for the deaf provided upon request)

A regular meeting. Public comment may be received at the beginning of the meeting upon notification at least five working days prior to the meeting.

Contact: D. Susan Hayden, Director of Public Affairs, State Board for Community Colleges, 101 N. 14th St., 15th Floor, Richmond, VA 23219, telephone (804) 819-4961, FAX (804) 819-4768, (804) 371-8504/TTY 

COMPENSATION BOARD

January 13, 2004 - 2 p.m. -- Open Meeting
January 21, 2004 - 11 a.m. -- Open Meeting
Compensation Board, 202 North 9th Street, 10th Floor, Richmond, Virginia. 

A monthly board meeting.

Contact: Cindy P. Waddell, Administrative Staff Assistant, Compensation Board, P.O. Box 710, Richmond, VA 23218, telephone (804) 786-0786, FAX (804) 371-0235, e-mail cwaddell@scb.state.va.us.

COMMONWEALTH COMPETITION COUNCIL

† **January 7, 2004 - 10 a.m.** -- Open Meeting
General Assembly Building, 9th and Broad Streets, Senate Room B, Richmond, Virginia.  (Interpreter for the deaf provided upon request)

A regular meeting.

Contact: Peggy R. Robertson, Acting Executive Director, Commonwealth Competition Council, 805 E. Broad St., 113 Eighth Street Office Building, Richmond, VA 23219, telephone (804) 786-0240, FAX (804) 786-1594, e-mail probertson@ccc.state.va.us.

DEPARTMENT OF CONSERVATION AND RECREATION

Virginia Soil and Water Conservation Board

January 23, 2004 - 11 a.m. -- Open Meeting
Natural Resources Conservation Service, 1606 Santa Rosa Road, Richmond, Virginia.

A regular business meeting. Following the regular business meeting, the board will conduct a hearing regarding an appeal filed under the Agricultural Stewardship Act.

Contact: Leon E. App, Acting Deputy Director, Department of Conservation and Recreation, 203 Governor St., Suite 302, Richmond, VA 23219, telephone (804) 786-6124, FAX (804) 786-6141, e-mail leonapp@dcr.state.va.us.

BOARD FOR CONTRACTORS

January 6, 2004 - 9 a.m. -- Open Meeting
January 13, 2004 - 9 a.m. -- Open Meeting
January 15, 2004 - 9 a.m. -- Open Meeting
† **January 20, 2004 - 2 p.m.** -- Open Meeting
January 27, 2004 - 9 a.m. -- Open Meeting
February 3, 2004 - 9 a.m. -- Open Meeting
February 10, 2004 - 9 a.m. -- Open Meeting
February 11, 2004 - 1:30 p.m. -- CANCELED
February 18, 2004 - 9 a.m. -- Open Meeting
February 24, 2004 - 9 a.m. -- Open Meeting
† **February 26, 2004 - 9 a.m.** -- Open Meeting
March 9, 2004 - 9 a.m. -- Open Meeting
Department of Professional and Occupational Regulation, 3600 West Broad Street, Richmond, Virginia.  (Interpreter for the deaf provided upon request)

January 7, 2004 - 2 p.m. -- Open Meeting
City of Virginia Beach, Department of Economic Development, 222 Central Park Avenue, Suite 1000, Virginia Beach, VA.

Informal fact-finding conferences. Persons desiring to participate in the meeting and requiring special accommodations or interpretive services should contact the department at (804) 367-0946 at least 10 days prior to the meeting so that suitable arrangements can be made for appropriate accommodations. The department fully complies with the Americans with Disabilities Act.

Contact: Eric L. Olson, Executive Director, Board for Contractors, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-2785, FAX (804) 367-2474, (804) 367-9753/TTY , e-mail contractors@dpor.state.va.us.

February 11, 2004 - 10 a.m. -- Open Meeting
Department of Professional and Occupational Regulation, 3600 West Broad Street, Richmond, Virginia. 

A meeting of the Tradesman and Education Committee to conduct committee business. The department fully complies with the Americans with Disabilities Act.

Contact: Eric L. Olson, Executive Director, Board for Contractors, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-2785, FAX (804) 367-2474, (804) 367-9753/TTY , e-mail contractors@dpor.state.va.us.

† **January 20, 2004 - 9 a.m.** -- Open Meeting
† **March 2, 2004 - 9 a.m.** -- Open Meeting
Department of Professional and Occupational Regulation, 3600 West Broad Street, Richmond, Virginia. 

A regular meeting that will address policy and procedural issues, review and render decisions on applications for contractors' licenses, and review and render case decisions on matured complaints against licensees. The meeting is open to the public; however, a portion of the board's business may be conducted in closed session.

Contact: Eric L. Olson, Executive Director, Board for Contractors, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-2785, FAX (804) 367-2474, (804) 367-9753/TTY , e-mail contractors@dpor.state.va.us.

BOARD OF COUNSELING

† **February 12, 2004 - 10 a.m.** -- Open Meeting
Department of Health Professions, 6603 West Broad Street,
5th Floor, Conference Room 3, Richmond, Virginia. 

The Credentials Committee will meet to review and discuss applicant credentials.

Contact: Evelyn B. Brown, Executive Director, Board of Counseling, Alcoa Bldg., 6603 W. Broad St., 5th Floor, Richmond, VA 23230-1712, telephone (804) 662-9912, FAX (804) 662-9943, (804) 662-7197/TTY , e-mail evelyn.brown@dhp.state.va.us.

† **February 13, 2004 - 9 a.m.** -- Open Meeting
Department of Health Professions, 6603 West Broad Street,
5th Floor, Room 1, Richmond, Virginia. 

A meeting of the Executive Committee to review the board meeting agenda. There will be no public comment.

Contact: Evelyn B. Brown, Executive Director, Board of Counseling, Alcoa Bldg., 6603 W. Broad St., 5th Floor, Richmond, VA 23230-1712, telephone (804) 662-9912, FAX (804) 662-9943, (804) 662-7197/TTY , e-mail evelyn.brown@dhp.state.va.us.

† **February 13, 2004 - 10 a.m.** -- Open Meeting
Department of Health Professions 6603 West Broad Street,
5th Floor, Conference Room 1, Richmond, Virginia. 

A business meeting to include reports from standing committees and any other disciplinary or regulatory matters as may be presented on the agenda. Public comment will be received at the beginning of the meeting.

Contact: Evelyn B. Brown, Executive Director, Board of Counseling, Alcoa Bldg., 6603 W. Broad St., 5th Floor, Richmond, VA 23230-1712, telephone (804) 662-9912, FAX (804) 662-9943, (804) 662-7197/TTY , e-mail evelyn.brown@dhp.state.va.us

† **January 30, 2004 - 9 a.m.** -- Open Meeting
Department of Health Professions, 6603 West Broad Street,
5th Floor, Richmond, Virginia. 

An Informal Conference Committee will meet to hold informal conferences pursuant to § 2.2-4019 of the Code of Virginia. The committee will meet in open and closed sessions.

Contact: Evelyn B. Brown, Executive Director, Board of Counseling, 6603 W. Broad St., 6th Floor, Richmond, VA 23230, telephone (804) 662-9912, FAX (804) 662-7250, (804) 662-7197/TTY , e-mail coun@dhp.state.va.us.

† **February 13, 2004 - 10 a.m.** -- Public Hearing
Department of Health Professions, 6603 West Broad Street,
5th Floor, Richmond, Virginia. 

February 27, 2004 - Public comments may be submitted until this date.

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the Board of Counseling intends to amend regulations entitled **18 VAC 115-20, Regulations Governing the Practice of Professional Counseling, 18 VAC 115-50, Regulations Governing the Practice of Marriage and Family Therapy, and 18 VAC 115-60, Regulations Governing the Practice of Licensed Substance Abuse Treatment Practitioners.** The purpose of the proposed action is to comply with a statutory mandate to require continuing education. The board is proposing a requirement of 20 hours per year and a provision for an inactive licensure status to accommodate individuals who are not actively practicing and who may be unable to meet the continuing competency requirements.

Statutory Authority: §§ 54.1-103, 54.1-2400 and 54.1-3505.1 of the Code of Virginia.

Public comments may be submitted until February 27, 2004, to Evelyn B. Brown, Executive Director, Board of Counseling, 6603 West Broad Street, 6th Floor, Richmond, VA 23230.

Contact: Elaine J. Yeatts, Agency Regulatory Coordinator, Department of Health Professions, 6606 W. Broad St., Richmond, VA 23230, telephone (804) 662-9918, FAX (804) 662-9114 or e-mail elaine.yeatts@dhp.state.va.us.

BOARD OF DENTISTRY

January 9, 2004 - 9 a.m. -- Open Meeting
Department of Health Professions, 6603 West Broad Street,
5th Floor, Richmond, Virginia. 

The Special Conference Committee will meet to hold informal conferences. There will not be a public comment period.

Contact: Cheri Emma-Leigh, Operations Manager, Department of Health Professions, 6603 W. Broad St., 5th Floor, Richmond, VA 23230, telephone (804) 662-9906, FAX (804) 662-7246, (804) 662-7197/TTY , e-mail Cheri.Emma-Leigh@dhp.state.va.us.

† **January 22, 2004 - 9 a.m.** -- Public Hearing
Department of Health Professions, 6603 West Broad Street,
5th Floor, Richmond, Virginia. 

February 27, 2004 - Public comments may be submitted until this date.

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the Board of Dentistry intends to amend regulations entitled **18 VAC 60-20, Regulations Governing the Practice of Dentistry and Dental Hygiene.** The purpose of the proposed action is to update certain requirements and terminology, to clarify the board's requirements, especially related to dental education, to eliminate a jurisprudence examination and add requirements for additional training for applicants who have had multiple examination failures. Amendments also modify educational, monitoring and equipment requirements for

Calendar of Events

administration of various forms of analgesia, sedation and anesthesia as minimally necessary to ensure public safety.

Statutory Authority: § 54.1-2400 and Chapter 27 (§ 54.1-2700 et seq.) of Title 54.1 of the Code of Virginia.

Public comments may be submitted until February 27, 2004, to Sandra Reen, Executive Director, Board of Dentistry, 6603 West Broad Street, 6th Floor, Richmond, VA 23230.

Contact: Elaine J. Yeatts, Agency Regulatory Coordinator, Department of Health Professions, 6606 W. Broad St., Richmond, VA 23230, telephone (804) 662-9918, FAX (804) 662-9114 or e-mail elaine.yeatts@dhp.state.va.us.

DESIGN-BUILD/CONSTRUCTION MANAGEMENT REVIEW BOARD

† **January 15, 2004 - 11 a.m.** -- Open Meeting
Department of General Services, Eighth Street Office Building, 3rd Floor, Richmond, Virginia.  (Interpreter for the deaf provided upon request)

A monthly meeting to review requests submitted by localities to use the design-build or construction management type contracts. Contact Division of Engineering and Building to confirm meeting. Board rules and regulations can be obtained online at www.dgs.state.va.us under DGS Forms, Form # DGS-30-904.

Contact: Rhonda M. Bishton, Administrative Assistant, Department of General Services, 805 E. Broad Street, Room 101, Richmond, VA 23219, telephone (804) 786-3263, FAX (804) 371-7934, (804) 786-6152/ , or e-mail rbishton@dgs.state.va.us.

VIRGINIA ECONOMIC DEVELOPMENT PARTNERSHIP

January 9, 2004 - 10 a.m. -- Open Meeting
Troutman Sanders, LLP, 222 Central Park Drive, Suite 2000, Virginia Beach, Virginia. 

A quarterly meeting of the Virginia Commission on Military Bases.

Contact: Cynthia H. Arrington, Communications Manager, Virginia Economic Development Partnership, P.O. Box 798, Richmond, VA 23218, telephone (804) 225-3743, FAX (804) 786-1121, e-mail carrington@yesvirginia.org.

BOARD OF EDUCATION

January 7, 2004 - 9 a.m. -- Open Meeting
February 25, 2004 - 9 a.m. -- Open Meeting
James Monroe Building, 101 North 14th Street, Conference Rooms C and D, Richmond, Virginia.  (Interpreter for the deaf provided upon request)

† **March 24, 2004 - 9 a.m.** -- Open Meeting

General Assembly Building, 9th and Broad Streets, Senate Room B, Richmond, Virginia.  (Interpreter for the deaf provided upon request)

A regular business meeting of the board. Persons who wish to speak or who require the services of an interpreter for the deaf should contact the agency 72 hours in advance. Public comment will be received.

Contact: Dr. Margaret N. Roberts, Office of Policy and Public Affairs, Department of Education, P.O. Box 2120, James Monroe Bldg., 101 N. 14th St., 25th Floor, Richmond, VA 23219, telephone (804) 225-2540, FAX (804) 225-2524, e-mail mroberts@mail.vak12ed.edu.

January 7, 2004 - 11:30 a.m. -- Public Hearing
James Monroe Building, 101 North 14th Street, Conference Rooms D and E, Richmond, Virginia.

February 2, 2004 - Public comments may be submitted until this date.

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the Board of Education intends to adopt regulations entitled **8 VAC 20-670, Regulations Governing the Operation of Private Day Schools for Students with Disabilities**. Private day schools for students with disabilities are currently regulated by the Regulations Governing the Operation of Proprietary Schools and Issuing of Agent Permits, which also covers private career schools. The purpose of these planned regulations is to separate the current complex and intertwined regulations. It is intended that revised regulations for the career schools and new regulations for the private day schools for students with disabilities be promulgated to provide clarity and specificity for each type of school.

Statutory Authority: §§ 22.1-16 and 22.1-321 of the Code of Virginia.

Contact: Carolyn Hodgins, Specialist, Private Day Schools, Department of Education, P.O. Box 2120, Richmond, VA 23218, telephone (804) 225-4551 or FAX (804) 225-2524.

January 7, 2004 - 11:45 a.m. -- Public Hearing
James Monroe Building, 101 North 14th Street, Conference Rooms D and E, Richmond, Virginia.

February 2, 2004 - Public comments may be submitted until this date.

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the Board of Education intends to amend regulations entitled **8 VAC 20-340, Regulations Governing Driver Education**. The purpose of the proposed action is to require a minimum number of miles driven during the behind-the-wheel phase of driver education instruction pursuant to amendments to § 22.1-205 of the 2001 Acts of Assembly.

Statutory Authority: §§ 22.1-16, 22.1-205 and 46.2-334 of the Code of Virginia.

Contact: Vanessa Wigand, Specialist in Driver Education, Department of Education, P.O. Box 2120, Richmond, VA 23218, telephone (804) 225-3300 or FAX (804) 225-2524.

DEPARTMENT OF EDUCATION

Advisory Board on Teacher Education and Licensure

January 26, 2004 - 9 a.m. -- Open Meeting

March 15, 2004 - 9 a.m. -- Open Meeting

Sheraton Richmond West, 6624 West Broad Street, Richmond, Virginia.  (Interpreter for the deaf provided upon request)

A meeting of the Advisory Board on Teacher Education and Licensure. The public is urged to confirm arrangements prior to each meeting by viewing the Department of Education's public meeting calendar at <http://www.pen.k12.va.us/VDOE/meetings.html>. This site will contain the latest information on the meeting arrangements and will note any last minute changes in time or location. Persons requesting the services of an interpreter for the deaf are asked to do so at least 72 hours in advance so that the appropriate arrangements may be made.

Contact: Dr. Margaret N. Roberts, Office of Policy and Public Affairs, Department of Education, P.O. Box 2120, 101 N. 14th St., 25th Floor, Richmond, VA 23219, telephone (804) 225-2540, FAX (804) 225-2524, e-mail mroberts@mail.vak12ed.edu.

DEPARTMENT OF ENVIRONMENTAL QUALITY

† **January 12, 2004 - 7 p.m.** -- Public Hearing

Willett Hall, 3701 Willet Drive, Portsmouth, Virginia. 

A public hearing to receive comments on a draft solid waste permit amendment for the City of Portsmouth Craney Island CDD Landfill located in Portsmouth. The amendment will establish permit modules X and XI and attach a ground water monitoring plan. The public comment period closes on January 27, 2004.

Contact: Rachel Borum, Department of Environmental Quality, P.O. Box 10009, Richmond, VA 23240, telephone (757) 518-2145, e-mail rcorum@deq.state.va.us.

January 20, 2004 - 7 p.m. -- Open Meeting

Department of Environmental Quality, Piedmont Regional Office, 4949-A Cox Road, Glen Allen, Virginia. 

A public meeting on the development of the bacteria and dissolved oxygen TMDL for Tuckahoe Creek, Little Tuckahoe Creek and Deep Run in Henrico County. The public notice will be published in the Virginia Register on December 15, 2003, and the public comment period closes on February 20, 2004.

Contact: Mark Alling, Department of Environmental Quality, 4949-A Cox Road, Glen Allen, VA 23060, telephone (804) 527-5021, FAX (804) 527-5106, e-mail msalling@deq.state.va.us.

January 22, 2004 - 7 p.m. -- Open Meeting

Hanover Volunteer Company #3, 4428 Mechanicsville Turnpike, Meeting Room, Mechanicsville, Virginia. 

A public meeting on the development of bacteria and pH TMDLs for Matadequin Creek in Hanover County. The public notice will be published in the Virginia Register on December 15, 2003, and the public comment period closes on February 22, 2004.

Contact: Mark Alling, Department of Environmental Quality, 4949-A Cox Road, Glen Allen, VA 23060, telephone (804) 527-5021, FAX (804) 527-5106, e-mail msalling@deq.state.va.us.

January 29, 2004 - 7 p.m. -- Open Meeting

Fairfield Area Library, 1001 North Laburnum Avenue, Richmond, Virginia. 

A meeting on the development of bacteria and pH TMDLs for White Oak Swamp Creek and Fourmile Creek in Henrico County. The public notice will be published in the Virginia Register on December 15, 2003, and the public comment period closes on February 22, 2004.

Contact: Mark Alling, Department of Environmental Quality, 4949-A Cox Road, Glen Allen, VA 23060, telephone (804) 527-5021, FAX (804) 527-5106, e-mail msalling@deq.state.va.us.

BOARD FOR GEOLOGY

January 6, 2004 - 9 a.m. -- Open Meeting

Department of Professional and Occupational Regulation, 3600 West Broad Street, Richmond, Virginia. 

A meeting to conduct board business.

Contact: David E. Dick, Assistant Director, Department of Professional and Occupational Regulation, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-8595, FAX (804) 367-6128, (804) 367-9753/TTY , e-mail geology@dpor.state.va.us.

GEORGE MASON UNIVERSITY

January 28, 2004 - 9 a.m. -- Open Meeting

† **March 24, 2004 - 9 a.m.** -- Open Meeting

George Mason University, Mason Hall, Fairfax, Virginia. 

A meeting of the Board of Visitors. The agenda will be published 10 days prior to the meeting.

Contact: Mary Roper, Secretary, pro tem, George Mason University, MSN 3A1, 4400 University Dr., Fairfax, VA 22030, telephone (703) 993-8703, (703) 993-8707/TTY , e-mail mroper@gmu.edu.

Calendar of Events

DEPARTMENT OF HEALTH

Radiation Advisory Board

† **December 30, 2003 - 9 a.m.** -- Open Meeting
James Madison Building, 109 Governor Street, Room 730, 7th Floor, Richmond, Virginia. 

A meeting to discuss radiological issues.

Contact: Les Foldesi, M.S., CHP, Director, Radiological Health Program, Department of Health, 109 Governor St., Room 730, Richmond, VA 23218, telephone (804) 864-8151, FAX (804) 864-8155, toll-free (800) 468-0138, (804) 828-1120/TTY 

Sewage Handling and Disposal Appeal Review Board

† **January 21, 2004 - 10 a.m.** -- Open Meeting
† **February 25, 2004 - 10 a.m.** -- Open Meeting
Henrico County Health Department, 8600 Dixon Powers Drive, Human Services Board Room, Richmond, Virginia.

A meeting to hear appeals of the health department denials of septic tank permits.

Contact: Susan C. Sherertz, Secretary to the Board, Department of Health, 109 Governor St., 5th Floor, Richmond, VA 23219, telephone (804) 864-7464, FAX (804) 864-7476, e-mail susan.sherertz@vdh.virginia.gov.

DEPARTMENT OF HEALTH PROFESSIONS

† **February 6, 2004 - 9 a.m.** -- Public Hearing
Department of Health Professions, 6603 West Broad Street, 5th Floor, Board Room 4, Richmond, Virginia.

February 27, 2004 -- Public comments may be submitted until this date.

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the Department of Health Professions intends to adopt regulations entitled **18 VAC 76-40, Regulations Governing Emergency Contact Information**. The purpose of the proposed action is to set forth requirements for collection of emergency contact information.

Statutory Authority: § 54.1-2506.1 of the Code of Virginia.

Public comments may be submitted until February 27, 2004, to Robert A. Nebiker, Director, Department of Health Professions, 6603 West Broad Street, Richmond, VA 23230-1712.

Contact: Elaine J. Yeatts, Agency Regulatory Coordinator, Department of Health Professions, 6606 W. Broad St., Richmond, VA 23230, telephone (804) 662-9918, FAX (804) 662-9114 or e-mail elaine.yeatts@dhp.state.va.us.

STATE COUNCIL OF HIGHER EDUCATION FOR VIRGINIA

† **January 20, 2004 - 10 a.m.** -- Open Meeting
State Council of Higher Education, 101 N. 14th St., 9th Floor, Main Conference Room, Richmond, VA.

A regular meeting. Agenda materials will be available on the website approximately one week prior to the meeting at www.schev.edu. A public comment period will be allocated on the meeting agenda. To be scheduled, those interested in making public comment should contact the person listed below no later than 5 p.m. three business days prior to the meeting date. At the time of the request, the speaker's name, address and topic must be provided. Each speaker will be given up to three minutes to address SCHEV. Speakers are asked to submit a written copy of their remarks at the time of comment.

Contact: Lee Ann Rung, State Council of Higher Education for Virginia, 101 N. 14th St., Richmond, VA 23219, telephone (804) 225-2602, FAX (804) 371-7911, e-mail LeeAnnRung@schev.edu.

HOPEWELL INDUSTRIAL SAFETY COUNCIL

† **January 6, 2004 - 9 a.m.** -- Open Meeting
† **February 3, 2004 - 9 a.m.** -- Open Meeting
† **March 2, 2004 - 9 a.m.** -- Open Meeting
Hopewell Community Center, 100 West City Point Road, Hopewell, Virginia.  (Interpreter for the deaf provided upon request)

A Local Emergency Preparedness committee meeting as required by SARA Title III.

Contact: Robert Brown, Emergency Services Coordinator, Hopewell Industrial Safety Council, 300 N. Main St., Hopewell, VA 23860, telephone (804) 541-2298.

BOARD OF HOUSING AND COMMUNITY DEVELOPMENT

January 20, 2004 - 10 a.m. -- Open Meeting
Department of Housing and Community Development, 501 North 2nd Street, Richmond, Virginia. 

A general business meeting.

Contact: Stephen W. Calhoun, Regulatory Coordinator, Department of Housing and Community Development, The Jackson Center, 501 N. 2nd St., Richmond, VA 23219-1321, telephone (804) 371-7000, FAX (804) 371-7090, (804) 371-7089/TTY , e-mail scalhoun@dhcd.state.va.us.

JAMESTOWN-YORKTOWN FOUNDATION

January 9, 2004 - Noon -- Open Meeting
The Library of Virginia, 800 East Broad Street, Rooms A and B, Richmond, Virginia.  (Interpreter for the deaf provided upon request)

A meeting of the Jamestown 2007 Steering Committee.

Contact: Stacey Ruckman, Jamestown 2007 Executive Assistant, Jamestown-Yorktown Foundation, P.O. Box 1607, Williamsburg, VA 23187, telephone (757) 253-4659, FAX (757) 253-5299, toll-free (888) 593-4682, (757) 253-7236/TTY ☎, e-mail sruckman@jyf.state.va.us.

DEPARTMENT OF LABOR AND INDUSTRY

Migrant and Seasonal Farmworkers Board

January 28, 2004 - 10 a.m. -- Open Meeting
Virginia State University, Agriculture Building, Petersburg, Virginia. ♿ (Interpreter for the deaf provided upon request)

A regular quarterly meeting.

Contact: Betty B. Jenkins, Board Administrator, Department of Labor and Industry, Powers-Taylor Bldg., 13 S. 13th St., Richmond, VA 23219, telephone (804) 786-2391, FAX (804) 371-6524, (804) 786-2376/TTY ☎, e-mail bbj@doli.state.va.us.

STATE LIBRARY BOARD

January 23, 2004 - 8:15 a.m. -- Open Meeting
March 15, 2004 - 8:15 a.m. -- Open Meeting
The Library of Virginia, 800 East Broad Street, Richmond, Virginia. ♿

Meetings of the board to discuss matters pertaining to the Library of Virginia and the board. Committees of the board will meet as follows:

8:15 - 9:15 a.m. - Public Library Development Committee
Publications and Educational Services Committee
Records Management Committee

9:30 - 10:30 a.m. - Archival and Information Services Committee
Collection Management Services Committee
Legislative and Finance Committee

10:30 a.m. - Library Board

Contact: Jean H. Taylor, Executive Secretary to the Librarian, The Library of Virginia, 800 E. Broad St., Richmond, VA 23219-2000, telephone (804) 692-3535, FAX (804) 692-3594, (804) 692-3976/TTY ☎, e-mail jtaylor@lva.lib.va.us.

COMMISSION ON LOCAL GOVERNMENT

January 12, 2004 - 10 a.m. -- Open Meeting
Department of Housing and Community Development, The Jackson Center, 501 North 2nd Street, First Floor Board Room, Richmond, Virginia. ♿ (Interpreter for the deaf provided upon request)

A regular meeting to consider such matters as may be presented.

Contact: Ted McCormack, Associate Director, Commission on Local Government, 501 N. 2nd St., Richmond, VA 23219, telephone (804) 786-6508, FAX (804) 371-7090, (800) 828-1120/TTY ☎, e-mail tmccormack@dhcd.state.va.us.

VIRGINIA MANUFACTURED HOUSING BOARD

† **January 15, 2004 - 10 a.m.** -- Open Meeting
Department of Housing and Community Development, The Jackson Center, 501 North 2nd Street, Richmond, Virginia. ♿ (Interpreter for the deaf provided upon request)

A regular meeting to review and make case decisions on complaints and claims involving licensees in the manufactured housing program and to carry out other administrative responsibilities in the manufactured housing licensing and transaction recovery fund program.

Contact: Curtis L. McIver, State Building Code Administrator, Virginia Manufactured Housing Board, 501 N. 2nd St., Richmond, VA 23219, telephone (804) 371-7160, FAX (804) 371-7092, (804) 371-7089/TTY ☎, e-mail Curtis.McIver@dhcd.virginia.gov.

MARINE RESOURCES COMMISSION

† **January 27, 2004 - 9:30 a.m.** -- Open Meeting
† **February 24, 2004 - 9:30 a.m.** -- Open Meeting
† **March 23, 2004 - 9:30 a.m.** -- Open Meeting
Marine Resources Commission, 2600 Washington Avenue, 4th Floor, Newport News, Virginia. ♿ (Interpreter for the deaf provided upon request)

A monthly commission meeting.

Contact: Jane McCroskey, Commission Secretary, Marine Resources Commission, 2600 Washington Ave., 3rd Floor, Newport News, VA 23607, telephone (757) 247-2248, FAX (757) 247-8101, toll-free (800) 541-4646, (757) 247-2292/TTY ☎, e-mail jmccroskey@mrc.state.va.us.

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

January 6, 2004 - 1 p.m. -- Open Meeting
Department of Medical Assistance Services, 600 East Broad Street, Board Room, Richmond, Virginia.

A meeting of the Virginia Pharmacy and Therapeutics Committee.

Contact: Adrienne T. Fegans, Program Operations Administrator, Department of Medical Assistance Services, 600 E. Broad St., Suite 1300, Richmond, VA 23219, telephone (804) 786-4112, FAX (804) 371-4981, (800) 343-0634/TTY ☎, e-mail afegans@dmas.state.va.us.

January 16, 2004 - Public comments may be submitted until this date.

Notice is hereby given in accordance with § 2.2-4007 that the Department of Medical Assistance Services intends to amend regulations entitled **12 VAC 30-130, Amount, Duration and Scope of Selected Services**. The purpose of the proposed action is to set reasonable limits on the amounts of money nursing facility residents may spend on noncovered medical care.

Calendar of Events

Statutory Authority: §§ 32.1-324 and 32.1-325 of the Code of Virginia.

Public comments may be submitted until January 16, 2004, to James Cohen, Director, Program Support, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219.

Contact: Victoria P. Simmons, Regulatory Coordinator, Department of Medical Assistance Services, 600 E. Broad St., Suite 1300, Richmond, VA 23219, telephone (804) 786-7959, FAX (804) 786-1680 or e-mail vsimmons@dmas.state.va.us.

January 16, 2004 - Public comments may be submitted until this date.

Notice is hereby given in accordance with § 2.2-4007 that the Department of Medical Assistance Services intends to amend regulations entitled **12 VAC 30-80, Methods and Standards for Establishing Payment Rates; Other Types of Care**. The purpose of the proposed action is to limit outpatient hospital costs that are allowable for reimbursement to 80% and to establish a prospective methodology to reimburse rehab agencies.

Statutory Authority: §§ 32.1-324 and 32.1-325 of the Code of Virginia.

Public comments may be submitted until January 16, 2004, to Steve Ford, Manager, Division of Provider Reimbursement, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219.

Contact: Victoria P. Simmons, Regulatory Coordinator, Department of Medical Assistance Services, 600 E. Broad St., Suite 1300, Richmond, VA 23219, telephone (804) 786-7959, FAX (804) 786-1680 or e-mail vsimmons@dmas.state.va.us.

† **February 27, 2004** - Public comments may be submitted until this date.

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the Department of Medical Assistance Services intends to consider amending regulations entitled **12 VAC 30-60, Standards Established and Methods Used to Assure High Quality Care**, and **12 VAC 30-90, Methods and Standards for Establishing Payment Rates for Long-Term Care**. The purpose of the proposed action is to discontinue duplicative reimbursement for adult specialized care services in nursing facilities.

Statutory Authority: §§ 32.1-324 and 32.1-325 of the Code of Virginia.

Public comments may be submitted until February 27, 2004, to Paula Margolis, Reimbursement Analyst, Division of Provider Reimbursement, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, VA 23219.

Contact: Victoria P. Simmons, Regulatory Coordinator, Department of Medical Assistance Services, 600 East Broad

Street, Suite 1300, Richmond, VA 23219, telephone (804) 786-7959, FAX (804) 786-1680, or e-mail vsimmons@dmas.state.va.us.

BOARD OF MEDICINE

January 22, 2004 - 8:15 a.m. -- Public Hearing
Department of Health Professions, 6603 West Broad Street, 5th Floor, Board Room 2, Richmond, Virginia.

February 13, 2004 - Public comments may be submitted until this date.

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the Board of Medicine intends to amend regulations entitled **18 VAC 85-20, Regulations Governing the Practice of Medicine, Osteopathy, Podiatry and Chiropractic**. The purpose of the proposed action is to increase fees by \$77 per licensee for a biennial renewal, with other associated fees increased by a like amount. This regulatory action will replace the emergency regulations in effect since July 15, 2003. The fee increase is necessary because of a substantial increase in the number of disciplinary proceedings related to implementation of HB1441 of the 2003 Session of the General Assembly.

Statutory Authority: §§ 54.1-113 and 54.1-2400 of the Code of Virginia.

Public comments may be submitted until February 13, 2004, to William L. Harp, M.D., Executive Director, Board of Medicine, 6603 West Broad Street, Richmond, VA 23230.

Contact: Elaine J. Yeatts, Agency Regulatory Coordinator, Department of Health Profession, 6603 W. Broad St., Richmond, VA 23230, telephone (804) 662-9918, FAX (804) 662-9114 or e-mail elaine.yeatts@dhp.state.va.us.

February 4, 2004 - 9 a.m. -- Open Meeting
Williamsburg Marriott, 50 Kingsmill Road, Williamsburg, Virginia.

An informal conference committee meeting to inquire into allegations that certain practitioners may have violated laws and regulations governing the practice of medicine and other healing arts in Virginia. The committee will meet in open and closed sessions pursuant to the Code of Virginia. Public comment will not be received.

Contact: Peggy Sadler or Renee Dixon, Staff, Department of Health Professions, 6603 W. Broad St., Richmond, VA 23230, telephone (804) 662-7332, FAX (804) 662-9517, (804) 662-7197/TTY ☎, e-mail Peggy.Sadler@dhp.state.va.us.

Advisory Board on Occupational Therapy

February 11, 2004 - 9 a.m. -- Open Meeting
Department of Health Professions, 6603 West Broad Street, 5th Floor, Board Room 4, Richmond, Virginia ♿

The board will consider issues related to the regulation of occupational therapy. Public comment will be received at the beginning of the meeting.

Contact: William L. Harp, M.D., Executive Director, Board of Medicine, Alcoa Bldg., 6603 W. Broad St., 5th Floor,

Richmond, VA 23230-1712, telephone (804) 662-9908, FAX (804) 662-9943, (804) 662-7197/TTY ☎, e-mail william.harp@dhp.state.va.us.

MOTOR VEHICLE DEALER BOARD

† **January 12, 2004 - 8:30 a.m.** -- Open Meeting
Department of Motor Vehicles, 2300 West Broad Street, Room 702, Richmond, Virginia. ♿ (Interpreter for the deaf provided upon request)

Committees will meet as follows:

- Dealer Practices Committee - 8:30 a.m.
- Franchise Law Committee - To be scheduled as needed
- Licensing Committee - Immediately following Dealer Practices
- Advertising Committee - 9:30 a.m. or immediately following Licensing
- Transaction Recovery Fund Committee - Immediately following Advertising

The full board will meet at 10:30 a.m. Meetings may begin later, but not earlier than scheduled. Meeting end times are approximate. Any person who needs any accommodation in order to participate in the meeting should contact the board at least 10 days before the meeting so that suitable arrangements can be made.

Contact: Alice R. Weedon, Administrative Assistant, Motor Vehicle Dealer Board, 2201 W. Broad St., Suite 104, Richmond, VA 23220, telephone (804) 367-1100, FAX (804) 367-1053, toll-free (877) 270-0203, e-mail dboard@mvb.state.va.us.

VIRGINIA MUSEUM OF FINE ARTS

January 6, 2004 - 8 a.m. -- Open Meeting
† **February 3, 2004 - 8 a.m.** -- Open Meeting
† **March 2, 2004 - 8 a.m.** -- Open Meeting
Virginia Museum of Fine Arts, 2800 Grove Avenue, Main Lobby Conference Room, Richmond, Virginia. ♿

A meeting for staff to update the Executive Committee. Public comment will not be received.

Contact: Suzanne Broyles, Secretary of the Museum, Virginia Museum of Fine Arts, 2800 Grove Ave., Richmond, VA 23221, telephone (804) 340-1503, FAX (804) 340-1502, (804) 340-1401/TTY ☎, e-mail sbroyles@vmfa.state.va.us.

BOARD OF NURSING

† **January 13, 2004 - 9 a.m.** -- Open Meeting
† **February 2, 2004 - 9 a.m.** -- Open Meeting
† **February 5, 2004 - 9 a.m.** -- Open Meeting
† **February 10, 2004 - 9 a.m.** -- Open Meeting
† **February 17, 2004 - 9 a.m.** -- Open Meeting
† **February 25, 2004 - 9 a.m.** -- Open Meeting
Department of Health Professions, 6603 West Broad Street, 5th Floor, Conference Room 3, Richmond, Virginia. ♿

A Special Conference Committee comprised of two or three members of the Virginia Board of Nursing will conduct informal conferences with licensees and/or certificate holders. Public comment will not be received.

Contact: Jay P. Douglas, R.N., M.S.M., C.S.A.C., Executive Director, Board of Nursing, 6603 W. Broad St., 5th Floor, Richmond, VA 23230, telephone (804) 662-9909, FAX (804) 662-9512, (804) 662-7197/TTY ☎, e-mail nursebd@dhp.state.va.us.

January 26, 2004 - 9 a.m. -- Open Meeting
January 28, 2004 - 9 a.m. -- Open Meeting
January 29, 2004 - 9 a.m. -- Open Meeting
† **March 22, 2004 - 9 a.m.** -- Open Meeting
† **March 24, 2004 - 9 a.m.** -- Open Meeting
† **March 25, 2004 - 9 a.m.** -- Open Meeting
Department of Health Professions, 6603 West Broad Street, 5th Floor, Conference Room 2, Richmond, Virginia. ♿

A panel of the board will conduct formal hearings with licensees or certificate holders. Public comment will not be received.

Contact: Jay P. Douglas, M.S.M., C.S.A.C., Executive Director, Board of Nursing, 6603 W. Broad St., 5th Floor, Richmond, VA 23230, telephone (804) 662-9909, FAX (804) 662-9512, (804) 662-7197/TTY ☎, e-mail nursebd@dhp.state.va.us.

January 27, 2004 - 9 a.m. -- Open Meeting
† **March 23, 2004 - 9 a.m.** -- Open Meeting
Department of Health Professions, 6603 West Broad Street, 5th Floor, Board Room 2, Richmond, Virginia. ♿

A general business meeting including committee reports, consideration of regulatory action, and disciplinary case decisions as presented on the agenda. Public comment will be received at 11 a.m.

Contact: Jay P. Douglas, R.N., Executive Director, Board of Nursing, Alcoa Bldg., 6603 W. Broad St., 5th Floor, Richmond, VA 23230-1712, telephone (804) 662-9909, FAX (804) 662-9512, (804) 662-7197/TTY ☎, e-mail jay.douglas@dhp.state.va.us.

January 27, 2004 - 11 a.m. -- Public Hearing
Department of Health Professions, 6603 West Broad Street, 5th Floor, Board Room 2, Richmond, Virginia.

February 13, 2004 - Public comments may be submitted until this date.

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the Board of Medicine intends to amend regulations entitled **18 VAC 90-20, Regulations Governing the Practice of Nursing**. The purpose of the proposed action is to increase certain fees for registered and licensed practical nurses to provide sufficient funding for an increased disciplinary caseload related to mandated reporting of misconduct and to offset the decrease in revenue related to Virginia's entry into the Nurse Licensure Compact in January 2005. The biennial renewal fee will

Calendar of Events

increase from \$70 to \$95 and other fees associated with the renewal fee will increase accordingly.

Statutory Authority: §§ 54.1-2400 and Chapter 30 (§ 54.1-3000 et seq.) of the Code of Virginia.

Public comments may be submitted until February 13, 2004, to Jay Douglas, R.N., Executive Director, Board of Nursing, 6603 West Broad Street, Richmond, VA 23230.

Contact: Elaine J. Yeatts, Agency Regulatory Coordinator, Department of Health Profession, 6603 W. Broad St., Richmond, VA 23230, telephone (804) 662-9918, FAX (804) 662-9114 or e-mail elaine.yeatts@dhp.state.va.us.

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† **January 27, 2004 - 11 a.m.** -- Public Hearing
Department of Health Professions, 6603 West Broad Street, 5th Floor, Board Room 2, Richmond, Virginia.

February 27, 2004 - Public comments may be submitted until this date.

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the Board of Medicine intends to amend regulations entitled **18 VAC 90-20, Regulations Governing the Practice of Nursing**. The purpose of the proposed action is to clarify and update certain provisions affecting nursing education programs, the practice of nursing, and medication administration programs. Current regulations for nurse aides and nurse aide education programs found within 18 VAC 90-20 are being repromulgated in a new set of regulations, 18 VAC 90-25, Regulations Governing Certified Nurses.

Statutory Authority: § 54.1-2400 and Chapter 30 (§ 54.1-3000 et seq.) of the Code of Virginia.

Public comments may be submitted until February 27, 2004, to Jay Douglas, R.N., Executive Director, Board of Nursing, 6603 West Broad Street, Richmond, VA 23230.

Contact: Elaine J. Yeatts, Agency Regulatory Coordinator, Department of Health Profession, 6603 W. Broad St., Richmond, VA 23230, telephone (804) 662-9918, FAX (804) 662-9114 or e-mail elaine.yeatts@dhp.state.va.us.

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† **January 27, 2004 - 11 a.m.** -- Public Hearing
Department of Health Professions, 6603 West Broad Street, 5th Floor, Board Room 2, Richmond, Virginia.

February 27, 2004 - Public comments may be submitted until this date.

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the Board of Nursing intends to amend regulations entitled **18 VAC 90-25, Regulations Governing Certified Nurse Aides**. The purpose of the proposed action is to clarify instructional expectations of the board for maintaining approval to provide nurse aide education, the process for reporting to the board for an interruption in the program. Regulations for reinstatement of nurse aide certification have been amended to include a prohibition

against reinstatement following a finding of abuse, neglect or misappropriation of property and incorporated a board guidance document that provides for the possibility of reinstatement if the finding of neglect was based on a single occurrence. There are additional grounds added to the disciplinary provisions that address situations encountered in disciplinary cases before the board.

Statutory Authority: § 54.1-2400 and Article 4 (§ 54.1-3022 et seq.) of Chapter 30 of the Code of Virginia.

Public comments may be submitted until February 13, 2004, to Jay Douglas, R.N., Executive Director, Board of Nursing, 6603 West Broad Street, Richmond, VA 23230.

Contact: Elaine J. Yeatts, Agency Regulatory Coordinator, Department of Health Profession, 6603 W. Broad St., Richmond, VA 23230, telephone (804) 662-9918, FAX (804) 662-9114 or e-mail elaine.yeatts@dhp.state.va.us.

February 18, 2004 - 9 a.m. -- Open Meeting
Department of Health Professions, 6603 West Broad Street, 5th Floor, Richmond, Virginia. 

A meeting of the Joint Boards of Nursing and Medicine.

Contact: Jay P. Douglas, R.N., M.S.M., C.S.A.C., Executive Director, Board of Nursing, 6603 W. Broad St., 5th Floor, Richmond, VA 23230, telephone (804) 662-9909, FAX (804) 662-9512, e-mail nursebd@dhp.state.va.us.

BOARD FOR OPTICIANS

January 9, 2004 - 9:30 a.m. -- Open Meeting
Department of Professional and Occupational Regulation, 3600 West Broad Street, Richmond, Virginia. 

A general business meeting including consideration of regulatory issues as may be presented on the agenda. The meeting is open to the public; however, a portion of the board's business may be discussed in closed session. Public comment will be heard at the beginning of the meeting. Persons desiring to participate in the meeting and requiring special accommodations or interpreter services should contact the department at least 10 days prior to the meeting so that suitable arrangements can be made. The department fully complies with the Americans with Disabilities Act.

Contact: William H. Ferguson, II, Executive Director, Board for Opticians, 3600 W. Broad St., Richmond, VA 23230-4917, telephone (804) 367-8590, FAX (804) 367-6295, (804) 367-9753/TTY , e-mail opticians@dpor.state.va.us.

BOARD OF OPTOMETRY

† **January 20, 2004 - 10:45 a.m.** -- Open Meeting
Department of Health Professions, 6603 West Broad Street, 5th Floor, Conference Room 4, Richmond, Virginia. 

A special conference hearing. This is a public meeting; however, public comment will not be received.

Contact: Elizabeth Carter, Ph.D., Executive Director, Board of Optometry, 6603 W. Broad St., 5th Floor, Richmond,

Virginia 23230, telephone (804) 662-9910, FAX (804) 662-7098, e-mail elizabeth.carter@dhp.state.va.us.

† **January 20, 2004 - 1 p.m.** -- Open Meeting
Department of Health Professions, 6603 West Broad Street,
5th Floor, Richmond, Virginia. 

A formal administrative hearing. This is a public meeting; however, public comment will not be received.

Contact: Elizabeth Carter, Executive Director, Board of Optometry, 6603 W. Broad St., 5th Floor, Richmond, VA 23230-1712, telephone (804) 662-9910, FAX (804) 662-7098, (804) 662-7197/TTY , e-mail elizabeth.carter@dhp.state.va.us.

BOARD OF PHARMACY

† **January 14, 2004 - 9 a.m.** -- Public Hearing
Department of Health Professions, 6603 West Broad Street,
5th Floor, Conference Room 2, Richmond, Virginia. 

February 27, 2004 - Public comments may be submitted until this date.

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the Board of Pharmacy intends to amend regulations entitled **18 VAC 110-20, Regulations Governing the Practice of Pharmacy**. The purpose of the proposed action is to clarify current law and regulation, alleviate problematic rules, and set more reasonable standards for reinstatement of a pharmacist license.

Statutory Authority: §§ 54.1-103 and 54.1-2400 and Chapters 33 (§ 54.1-3300) and 34 (§ 54.1-3400 et seq.) of the Code of Virginia.

Public comments may be submitted until February 27, 2004, to Elizabeth Scott Russell, Department of Health Professions, 6603 West Broad Street, Richmond, VA 23230.

Contact: Elaine J. Yeatts, Agency Regulatory Coordinator, Department of Health Profession, 6603 W. Broad St., Richmond, VA 23230, telephone (804) 662-9918, FAX (804) 662-9114 or e-mail elaine.yeatts@dhp.state.va.us.

January 14, 2004 - 9 a.m. -- Open Meeting
Department of Health Professions, 6603 West Broad Street,
5th Floor, Conference Room 2, Richmond, Virginia. 

The board will consider such regulatory and disciplinary matters as may be presented on the agenda. Public comment will be received at the beginning of the meeting.

Contact: Elizabeth Scott Russell, RPh, Executive Director, Board of Pharmacy, Alcoa Bldg., 6603 W. Broad St., 5th Floor, Richmond, VA 23230-1712, telephone (804) 662-9911, FAX (804) 662-9313, (804) 662-7197/TTY , e-mail scott.russell@dhp.state.va.us.

January 15, 2004 - 9 a.m. -- Open Meeting
Department of Health Professions, 6603 West Broad Street,
5th Floor, Conference Room 3, Richmond, Virginia. 

A Special Conference Committee will discuss disciplinary matters. Public comments will not be received.

Contact: Elizabeth Scott Russell, RPh., Executive Director, Board of Pharmacy, 6603 W. Broad St., 5th Floor, Richmond, VA 23230, telephone (804) 662-9911, FAX (804) 662-9313.

BOARD OF PSYCHOLOGY

January 13, 2004 - 9:30 a.m. -- Open Meeting
Department of Health Professions, 6603 West Broad Street,
5th Floor, Board Room 4, Richmond, Virginia. 

A board business meeting and informal conference.

Contact: Evelyn B. Brown, Executive Director, Board of Psychology, Alcoa Bldg., 6603 W. Broad St., 5th Floor, Richmond, VA 23230-1712, telephone (804) 662-9913, FAX (804) 662-9943, (804) 662-7197/TTY , e-mail evelyn.brown@dhp.state.va.us.

VIRGINIA PUBLIC BUILDINGS BOARD

† **January 28, 2004 - 10 a.m.** -- Open Meeting
Department of Education, James Monroe Building, 18th Floor
Conference Room, Richmond, Virginia. 

A meeting of the Master Plan Advisory Committee to wrap up input and recommendations regarding "education" within the Master Plan and to incorporate VPBB orientation feedback from November 19 and any additional input on larger issues. Following this meeting, all recommendations will go to the VPBB subcommittee(s) for further analysis and action.

Contact: Shannon Rainey, Research Assistant, Virginia Public Buildings Board, 202 N. 9th St., Suite 636, Richmond, VA 23219, telephone (804) 786-1201, FAX (804) 371-0038.

REAL ESTATE BOARD

† **January 8, 2004 - 9 a.m.** -- Open Meeting
January 22, 2004 - 2:30 p.m. -- Open Meeting
Department of Professional and Occupational Regulation,
3600 West Broad Street, Richmond, Virginia.  (Interpreter for the deaf provided upon request)

An informal fact-finding conference.

Contact: Karen W. O'Neal, Regulatory Programs Coordinator, Department of Professional and Occupational Regulation, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-8537, FAX (804) 367-2475, (804) 367-9753/TTY , e-mail oneal@dpor.state.va.us.

VIRGINIA RESOURCES AUTHORITY

January 13, 2004 - 9 a.m. -- Open Meeting
February 10, 2004 - 9 a.m. -- Open Meeting
Eighth and Main Building, 707 East Main Street, 2nd Floor,
Richmond, Virginia. 

A regular meeting of the Board of Directors to (i) review and, if appropriate, approve the minutes from the most recent monthly meeting; (ii) review the authority's operations for the prior month; (iii) review applications for

Calendar of Events

loans submitted to the authority for approval; (iv) consider loan commitments for approval and ratification under its various programs; (v) approve the issuance of any bonds; (vi) review the results of any bond sale; and (vii) consider such other matters and take such other actions as it may deem appropriate. Various committees of the Board of Directors may also meet immediately before or after the regular meeting and consider matters within their purview. The planned agenda of the meeting and any committee meetings will be available at the offices of the authority one week prior to the date of the meeting. Any person who needs any accommodation in order to participate in the meeting should contact the authority at least 10 days before the meeting so that suitable arrangements can be made.

Contact: Bonnie R. C. McRae, Executive Assistant, Virginia Resources Authority, 707 E. Main St., Richmond, VA 23219, telephone (804) 644-3100, FAX (804) 644-3109, e-mail bmcr@vra.state.va.us.

COMMONWEALTH TRANSPORTATION BOARD

† **January 14, 2004 - 2 p.m.** -- Open Meeting
Virginia Department of Transportation, 1221 East Broad Street, Central Auditorium, Richmond, Virginia. 

A work session of the Commonwealth Transportation Board, Virginia Department of Transportation and the Department of Rail and Public Transportation staff.

Contact: Katherine Tracy, Assistant Secretary to the Commonwealth Transportation Board, Department of Transportation, Policy Division, 1401 E. Broad St. Richmond, VA 23219, telephone (804) 786-3090, FAX (804) 225-4700, e-mail katherine.tracy@viriniadot.org.

† **January 15, 2004 - 9 a.m.** -- Open Meeting
Department of Transportation, 1221 East Broad Street, Central Auditorium, Richmond, VA 23219 

A meeting to vote on action items presented regarding bids, conveyances and any other matter requiring board approval. Public comments will be received at the outset of the meeting with remarks limited to five minutes. Groups are asked to select a spokesperson for the group. The board reserves the right to amend these conditions. Separate committee meetings may be held on the call of the chairman and will be posted separately. Contact Policy Division, CTB Section, 786-3090 for schedule and additional information.

Contact: Katherine Tracy, Assistant Secretary to the Commonwealth Transportation Board, Department of Transportation, Policy Division, 1401 E. Broad St. Richmond, VA 23219, telephone (804) 786-3090, FAX (804) 225-4700, e-mail katherine.tracy@viriniadot.org.

DEPARTMENT OF THE TREASURY

February 1, 2004 - Public comments may be submitted until this date.

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the Department of the Treasury

intends to adopt regulations entitled **1 VAC 75-40, Unclaimed Property Administrative Review Process**. The purpose of the proposed action is to allow any person asserting ownership of unclaimed property or any holder of unclaimed property who is aggrieved by a decision of the administrator of the Uniform Disposition of Unclaimed Property Act the opportunity to file an application for an administrative review of the administrator's decision, all in compliance with § 55-210.27 of the Code of Virginia.

Statutory Authority: § 55-210-27 of the Code of Virginia.

Contact: Vicki D. Bridgeman, Director of Unclaimed Property, James Monroe Bldg., 101 N. 14th St., 4th Floor, Richmond, VA 23219, telephone (804) 225-3156, FAX (804) 786-4653 or e-mail vicki.bridgeman@trs.state.va.us.

DEPARTMENT OF VETERANS SERVICES

January 12, 2004 - 1 p.m. -- Open Meeting
Virginia War Memorial, 621 South Belvidere Street, Richmond, Virginia. 

A meeting of the Board of Veterans Services. Subcommittees will also meet. Times to be announced for subcommittees.

Contact: Geneva M. Claybrook, Executive Services Liaison, Department of Veterans Services, P.O. Box 6129, Roanoke, VA 24017, telephone (540) 857-6974, FAX (540) 857-6954, toll-free (800) 220-8387, e-mail gclaybrook@vcc1.us.

STATE WATER CONTROL BOARD

January 7, 2004 - 2 p.m. -- Open Meeting
State Capitol, House Room 4, Richmond, Virginia. 

A public meeting to receive comments on the Notice of Intended Regulatory Action (NOIRA) to amend the Water Quality Standards (9 VAC 25-260) for Chesapeake Bay and Tidal Waters Criteria for Dissolved Oxygen, Water Clarity and Chlorophyll a and Designated Uses. The NOIRA will be published in the Virginia Register on November 17, 2003. The public comment period closes on January 15, 2004.

Contact: Eleanore Daub, Department of Environmental Quality, P.O. Box 10009, Richmond, VA 23240, telephone (804) 698-4111, FAX (804) 698-4522, e-mail emd@deq.state.va.us.

January 13, 2004 - 10 a.m. -- Public Hearing
Department of Environmental Quality, 4949-A Cox Road, Glen Allen, Virginia.

January 30, 2004 - Public comments may be submitted until this date.

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the State Water Control Board intends to amend regulations entitled **9 VAC 25-151, Virginia Pollutant Discharge Elimination System (VPDES) General Permit Regulation for Storm Water Discharges**

Associated with Industrial Activity. The purpose of the proposed action is to reissue the existing storm water industrial activity permit that expires on June 30, 2004. This general permit regulation governs the discharge of storm water from facilities with regulated industrial activities to surface waters.

Statutory Authority: § 62.1-44.15 of the Code of Virginia.

Contact: Burt Tuxford, Department of Environmental Quality, P.O. Box 10009, Richmond, VA 23240, telephone (804) 698-4086, FAX (804) 698-4032 or e-mail brtuxford@deq.state.va.us.

January 13, 2004 - 10 a.m. -- Public Hearing
Department of Environmental Quality, 4949-A Cox Road, Glen Allen, Virginia.

January 30, 2004 - Public comments may be submitted until this date.

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the State Water Control Board intends to amend regulations entitled **9 VAC 25-180, Virginia Pollutant Discharge Elimination System (VPDES) General Permit Regulation for Storm Water Discharges From Construction Sites**. The purpose of the proposed action is to reissue the existing storm water construction general permit that expires on June 30, 2004. This general permit regulation governs the discharge of storm water from construction sites to surface waters.

Statutory Authority: § 62.1-44.15 of the Code of Virginia.

Contact: Burt Tuxford, Department of Environmental Quality, P.O. Box 10009, Richmond, VA 23240, telephone (804) 698-4086, FAX (804) 698-4032 or e-mail brtuxford@deq.state.va.us.

January 13, 2004 - 10 a.m. -- Public Hearing
Department of Environmental Quality, 4949-A Cox Road, Glen Allen, Virginia.

January 30, 2004 - Public comments may be submitted until this date.

Notice is hereby given in accordance with § 2.2-4007 of the Code of Virginia that the State Water Control Board intends to amend regulations entitled **9 VAC 25-190, Virginia Pollutant Discharge Elimination System (VPDES) General Permit Regulation for Nonmetallic Mineral Mining**. The purpose of the proposed action is to reissue a general discharge permit for discharges from nonmetallic mineral mining operations.

Statutory Authority: § 62.1-44.15 of the Code of Virginia.

Contact: Michael B. Gregory, Department of Environmental Quality, P.O. Box 10009, Richmond, VA 23240, telephone (804) 698-4065, FAX (804) 698-4032 or e-mail mbgregory@deq.state.va.us.

BOARD FOR WATERWORKS AND WASTEWATER WORKS OPERATORS

March 9, 2004 - 8:30 a.m. -- Open Meeting
Department of Professional and Occupational Regulation, 3600 West Broad Street, Richmond, Virginia. ☎

A meeting to conduct board business.

Contact: David E. Dick, Executive Director, Board for Waterworks and Wastewater Works Operators, 3600 W. Broad St., Richmond, VA 23230, telephone (804) 367-8507, FAX (804) 367-6128, (804) 367-9753/TTY ☎, e-mail waterwasteoper@dpor.state.va.us.

INDEPENDENT

VIRGINIA RETIREMENT SYSTEM

† **January 13, 2004 - Noon** -- Open Meeting
† **January 27, 2004 - Noon** -- Open Meeting
† **February 10, 2004 - 1 p.m.** -- Open Meeting
VRS Headquarters, 1200 East Main Street, Richmond, Virginia. ☎

A meeting of the Optional Retirement Plan Advisory Committee. No public comment will be received at the meeting.

Contact: LaShaunda B. King, Executive Assistant, Virginia Retirement System, 1200 E. Main St., Richmond, VA 23219, telephone (804) 649-8059, FAX (804) 786-1541, toll-free (888) 827-3847, (804) 344-3190/TTY ☎, e-mail lking@vrs.state.va.us.

† **February 4, 2004 - 11 a.m.** -- Open Meeting
Bank of America Building, 1111 East Main Street, 4th Floor Conference Room, Richmond, Virginia.

The regular meeting of the Investment Advisory Committee of the VRS Board of Trustees. No public comment will be received at the meeting.

Contact: Phyllis Henderson, Investment Department Administrative Assistant, Virginia Retirement System, 1111 East Main Street, Richmond, Virginia 23219, telephone (804) 649-8059, FAX (804) 786-1541, toll-free (888) 827-3847, (804) 344-3190/TTY ☎, e-mail phenderson@vrs.state.va.us.

† **February 4, 2004 - 2:30 p.m.** -- Open Meeting
VRS Headquarters, 1200 East Main Street, Richmond, Virginia. ☎

Regular meetings of the following committees:
Administration and Personnel - 4 p.m.
Benefits and Actuarial - 2:30 p.m.
Audit and Compliance - 4 p.m.

Contact: LaShaunda B. King, Executive Assistant, Virginia Retirement System, P.O. Box 2500, Richmond, VA 23218, telephone (804) 649-8059, FAX (804) 786-1541, toll-free (888) 827-3847, (804) 344-3190/TTY ☎, e-mail lking@vrs.state.va.us.

Calendar of Events

† **February 5, 2004 - 9 a.m.** -- Open Meeting
VRS Headquarters, 1200 East Main Street, Richmond, Virginia. 

A regular meeting of the Board of Trustees. No public comment will be received.

Contact: LaShaunda B. King, Executive Assistant, Virginia Retirement System, P.O. Box 2500, Richmond, VA 23218, telephone (804) 649-8059, FAX (804) 786-1541, toll-free (888) 827-3847, (804) 344-3190/TTY , e-mail lking@vrs.state.va.us.

† **March 24, 2004 - 3 p.m.** -- Open Meeting
VRS Headquarters, 1200 East Main Street, Richmond, Virginia. 

A meeting of the Audit and Compliance Committee. No public comment will be received at the meeting.

Contact: LaShaunda B. King, Executive Assistant, Virginia Retirement System, 1200 E. Main Street, Richmond, VA 23219, telephone (804) 649-8059, FAX (804) 786-1541, toll-free (888) 827-3847, (804) 344-3190/TTY , e-mail lking@vrs.state.va.us.

CHRONOLOGICAL LIST

OPEN MEETINGS

December 30

† Health, Department of
- Radiation Advisory Board

December 31

At-Risk Youth and Families, Comprehensive Services for
- State Executive Council

January 6, 2004

Accountancy, Board of
Contractors, Board for
Geology, Board for
† Hopewell Industrial Safety Council
Medical Assistance Services, Department of
Museum of Fine Arts, Virginia

January 7

Asbestos, Lead, and Home Inspectors, Virginia Board for
† Competition Council, Commonwealth
Contractor, Board for
Education, Board of
Water Control Board, State

January 8

† Asbestos, Lead, and Home Inspectors, Virginia Board for
† Real Estate Board

January 9

† Agriculture and Consumer Services, Department of
- Virginia Sheep Industry Board
Art and Architectural Review Board
Dentistry, Board of
Economic Development Partnership, Virginia
Jamestown-Yorktown Foundation
Opticians, Board for

January 12

Agriculture and Consumer Services, Department of

- Virginia Irish Potato Board
Barbers and Cosmetology, Board for
Local Government, Commission on
† Motor Vehicle Dealer Board
Veterans Services, Board of

January 13

Compensation Board
Contractors, Board for
† Nursing, Board of
Psychology, Board of
Resources Authority, Virginia
† Retirement System, Virginia

January 14

Pharmacy, Board of
† Transportation Board, Commonwealth

January 15

Contractors, Board for
† Design-Build/Construction Management Review Board
† Manufactured Housing Board, Virginia
Pharmacy, Board of
† Transportation Board, Commonwealth

January 20

† Contractors, Board for
Environmental Quality, Department of
† Higher Education for Virginia, State Council of
Housing and Community Development, Board of
† Optometry, Board of

January 21

Cemetery Board
Community Colleges, State Board for
Compensation Board
† Health, Department of
- Sewage Handling and Disposal Appeal Review Board

January 22

Community Colleges, State Board for
Environmental Quality, Department of
Real Estate Board

January 23

Conservation and Recreation, Department of
- Virginia Soil and Water Conservation Board
Library Board, State

January 26

Education, Department of
- Advisory Board on Teacher Education and Licensure
Nursing, Board of

January 27

Contractors, Board for
† Marine Resources Commission
Nursing, Board of
† Retirement System, Virginia

January 28

George Mason University
Labor and Industry, Department of
- Migrant and Seasonal Farmworkers Board
Nursing, Board of
† Public Buildings Board, Virginia

January 29

Environmental Quality, Department of
Nursing, Board of

January 30

† Counseling, Board of

February 2

† Nursing, Board of

February 3

Contractors, Board for

† Hopewell Industrial Safety Council

February 4

† Agriculture and Consumer Services, Department of

- Virginia Horse Industry Board

Medicine, Board of

† Retirement System, Virginia

February 5

† Nursing, Board of

† Retirement System, Virginia

February 6

Accountancy, Board of

† Art and Architectural Review Board

February 10

Contractors, Board for

† Nursing, Board of

Resources Authority, Virginia

† Retirement System, Virginia

February 11

Contractors, Board for

Medicine, Board of

- Advisory Board on Occupational Therapy

February 12

† Counseling, Board of

February 13

† Counseling, Board of

February 17

† Nursing, Board of

February 18

Asbestos, Lead, and Home Inspectors, Virginia Board for

Contractors, Board for

Nursing and Medicine, Joints Boards for

February 19

Audiology and Speech-Language Pathology, Board of

February 24

Contractors, Board for

† Marine Resources Commission

February 25

Education, Board of

† Health, Department of

- Sewage Handling and Disposal Appeal Review Board

† Nursing, Board of

February 26

† Contractors, Board for

March 2

† Contractors, Board for

† Hopewell Industrial Safety Council

† Museum of Fine Arts, Virginia

March 5

† Art and Architectural Review Board

March 9

Contractors, Board for

Waterworks and Wastewater Works Operators, Board for

March 15

Barbers and Cosmetology, Board for

Education, Board of

- Advisory Board on Teacher Education and Licensure

Library Board, State

March 17

† Community Colleges, State Board for

March 18

† Community Colleges, State Board for

March 22

† Nursing, Board of

March 23

† Alzheimer's Disease and Related Disorders Commission

† Marine Resources Commission

† Nursing, Board of

March 24

† Education, Board of

† George Mason University

† Nursing, Board of

† Retirement System, Virginia

March 25

† Nursing, Board of

PUBLIC HEARINGS

January 7

Education, Board of

January 12

† Environmental Quality, Department of

January 13

Water Control Board, State

January 14

† Pharmacy, Board of

January 22

† Dentistry, Board of

Medicine, Board of

January 27

† Nursing, Board of

February 6

† Health Professions, Department of

February 13

† Counseling, Board of

Calendar of Events
